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**Organisational responses to students' mental health needs:
social, psychological and medical perspectives**

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the award of Doctor of Philosophy

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Abstract

This research examines the support offered to students with mental and emotional problems in Oxford, based on a theoretical model which distinguishes between social, psychological and medical/biological approaches. Although there has been a long-running debate about the contribution of each of these approaches, their impact on the provision of formal and informal support for students has not been previously studied.

Using a case study research design, 76 semi-structured interviews were conducted with students and staff within three educational institutions and two healthcare trusts, with additional information coming from meetings of the Oxford Student Mental Health Network and other documentary evidence. The case studies found that concerns about stigma, confidentiality, damaged career prospects and beliefs about the nature of the support provided all impacted on students' willingness to seek help. Sources of social support included friends, family, student officers, academic, residential and administrative staff. Psychological support came from university counsellors and National Health Service psychotherapists. General Practitioners provided the first line of medical support, with psychiatrists and other mental health professionals becoming involved with the more severe cases. There were gaps between the different levels of support, concerns about the difficulty in accessing secondary and tertiary levels of care, and sometimes mutual suspicion between different types of supporters.

The distinctions between social, psychological and medical approaches to mental health which tend to be polarised in the literature, were not articulated so forcefully by the majority of the respondents. Integrating different forms of support was seen as providing students with the best chance of completing their studies successfully, but raises challenges of working across organisational and professional boundaries. Whilst there were established pathways for referring students into psychological and medical services at times of crisis, there were not such well organised pathways back in to the social levels of support upon recovery.

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Introduction

This PhD research project was inspired by reading and reflection undertaken over a long period. It was also influenced by my work in the non-statutory mental health sector (vocational/work rehabilitation) and subsequently as university lecturer on disability and employment issues. As someone with a sociological rather than clinical background I wanted a better understanding of the causes of, and responses to, mental health problems. This interest coincided with significant changes affecting the further and higher education sectors in the UK. Widening participation initiatives combined with legal requirements that education providers meet the needs of disabled and disadvantaged students, had resulted in a greater awareness nationally of the difficulties faced by students with mental health problems.

From my academic background I had encountered social theories of mental health/illness and social models of disability. In my everyday work with adults experiencing major mental health problems I was aware of the key role that medical and psychological interventions played in their lives. When I encountered Tyrer and Steinberg's (1999) *Models for Mental Disorder* I was intrigued by the attempt to integrate social, psychological and medical approaches to mental health and illness. E-mail correspondence with one of the authors, Professor Peter Tyrer, established that he was not aware of any research that had attempted to test their model in practice. Although the model was developed with psychiatrists in mind, it was sufficiently broad to be applied to a whole network of support including non-medical professionals and informal supporters.

The Higher Education Funding Council for England (HEFCE) had recognised the need to develop good practice for supporting disabled students by funding a range of pilot projects from the mid 1990s onwards. Projects focusing on mental health issues were sponsored at the Universities of Hull, Leicester, Nottingham and Teesside from 1996 to 1999. A further round of mental health projects based in Lancaster, Nottingham and Oxford were given funding in 2000. The Oxford project differed from the others in that it involved not only universities and colleges as partners, but also the local Primary Care and Mental Health Trusts.

My employment as Project Manager/Researcher for the Oxford Student Mental Health Network, from June 2000 to June 2003 (see Appendix 2 and Chapter 3 for

details), provided the opportunity to examine the relevance of differing models of support for people with mental health problems in relation to the support and treatment offered to students in higher and further education in Oxford. In this context the term 'student' was taken to include people aged 16 and over for whom studying was a major part of their life. This automatically included the 28,000 or so full-time students at the college of further education and the two universities in Oxford¹, but also another group of approximately 8,000 students at these institutions who had a significant involvement in part-time study for qualifications and who met the criteria for accessing help from college and university-based support services. Many, but not all, of the students in higher education were living away from home. This was especially true in the case of the University of Oxford which had a lower proportion of mature students compared to Oxford Brookes University. People taking one-off adult education classes were not included in this study.

This research explores the perceptions of students and staff of the factors affecting the mental health of students, students' decisions about seeking support and the nature of support offered. These perceptions are compared to frameworks developed for social, psychological and medical approaches to mental health. It was beyond the scope of this research to measure the effectiveness of any particular approaches or interventions, but respondents' perceptions of their value was very relevant. Of particular interest was the relationship between different providers of support and the factors which either encouraged, or acted as a barrier to, an integrated approach.

The first chapter reviews the literature on different models and concepts of mental health looking at the nature of mental health and illness, ideas on causation and different approaches to support and treatment. Information from previous studies of the incidence of mental health problems in student populations is presented. Social, psychological and medical approaches to supporting students with mental health problems are examined in the literature on student support.

In Chapter 2 the research methods adopted for this research are explored. In particular a case study approach is proposed as providing the most appropriate means of studying the provision of support across five different organisations.

¹ See Table 3.2 in Chapter 3.

The research findings are discussed in Chapters 3 to 5. Chapter 3 sets out details of the local context in which the research took place and explores respondents' perceptions of what mental health problems are, what factors contribute to them and students' attitudes towards seeking help for those problems. Chapter 4 presents the findings of the case studies within the two universities and the college of further education. Chapter 5 contains details of the case studies of the local healthcare trusts involved in providing support for students with mental health problems, and explores the issues arising when collaboration with the universities and colleges is necessary or desirable. A summary of the key points arising can be found at the end of each chapter.

Chapter 6 discusses the significance of the research findings in the light of the issues raised in Chapter 1 and explores some possible implications for the provision of support services to students with mental health problems. At a wider level the possibilities of integrating social, psychological and medical approaches to mental health are explored. Suggestions are also made for topics which could usefully be followed up by further research.

The Appendices provide examples of the documentation used in the research process as well as data extracts from the interview notes illustrating the points made in Chapters 3 to 5.

The significance of this research in the present context of community-based care, anti-discrimination legislation, social inclusion and widening participation is that people with mental health problems are being actively encouraged to participate in mainstream activities including education, employment and leisure. An understanding of the role that support, both professional and non-professional/informal, can play in facilitating this process should help to increase the chances of these activities resulting in successful outcomes.

Chapter 1 Literature Review – Student Mental Health: Incidence of Problems, Concepts of Mental Health/Illness and the Provision of Support

This chapter starts with a review of previous studies of the mental health of students in further and higher education, comparing the results with information on the mental health of young adults and the general adult population. A substantial middle section of the chapter explores different approaches to mental health and illness potentially useful in understanding the types of support and treatment available to the student population. The final section examines commentaries on the provision of support for students in the UK providing a basis for comparisons with the findings from this research in Oxford.

The literature reviewed in this chapter reflects the diversity of views that have emerged from the continuing debate on the nature of mental health and illness. One way of categorising these different views is under the headings of social, psychological and medical (or biological) approaches to mental health. These approaches and certain authors' attempts to integrate them have influenced the formulation of the research questions in this thesis.

1.1 The mental health of students

In comparing the incidence of mental health problems amongst students with that in the general population and amongst young adults, it should be noted that an increasing proportion of the young adult population have become students over the last twenty years. Recently 41% of the population under the age of 30 have participated in higher education (DfES 2000) and the government target is for this to increase to 50% (Hansard 2002). The implications of this are that any comparisons made are between an all-student population and a general population that includes a significant proportion of students. If it were possible to remove students from these general population statistics, it is possible that any differences would be more marked. It is also important to note that the nature of the student population is changing and more mature students are entering further and higher education. Widening participation is a key objective for the higher education sectors and this has been suggested as one of the reasons for the increase in the numbers of students with mental health problems in universities and colleges (Rana et al.1999).

The Royal College of Psychiatrists (RCP 2003) considered student mental health sufficiently important to set up a specialist working party on the topic. Similarly, professional associations within higher education and student counselling have recently produced reports and guidelines (Rana et al. 1999, CVCP 2000, AMOSSHE 2001). However, the interest in student mental health in the UK can be traced back to the 1950s and 1960s when Davidson and colleagues (1955 & 1964) studied University of Oxford students who were psychiatric patients. In 1964 referral of Oxford students to psychiatric services was three times the national rate, but the researchers concluded that this might have been because there was an easy referral route to the Warneford Hospital for students with study problems. Kelvin et al. (1965) found that a sample of students had higher levels on a measure of neuroticism than the general population.

1.1.1 Measures of mental health and illness

Many different measures of mental health and illness have been used in studies of general and student populations, making comparisons difficult. Goldberg and Huxley (1980 and 1992) used the General Health Questionnaire (GHQ) within communities to record symptoms of mental illnesses which lasted more than two weeks within a calendar year. The GHQ has also been used with student populations (Table 1.1). More recent general population figures produced for the Office of National Statistics (Singleton et al. 2001) used different assessment instruments and were based on the experience of symptoms in the week before the respondent was interviewed. Other measures used in general and student populations include the Hospital Anxiety and Depression Scale (HADS) and the Short Form Health Status measurement tool (SF36). Although it would be useful to distinguish between students with emotional upsets, normal anxiety etc. and those with serious mental health problems, the different measures used vary in the extent to which they are designed or are able to detect clinical conditions.

In order to find information on the mental health of UK student populations, searches were made on the following databases: PubMed, ISI Web of Science, PsychINFO and the Index to Theses, as well as the online catalogues of the Bodleian and British Libraries. Searches used terms such as 'student', 'university' or 'college' in combination with others such as 'mental', 'health', 'illness', 'stress' or 'counselling/counseling'. Where relevant articles and publications were found, their reference lists were checked for any additional material. In addition the same terms

were used for an internet search in combination with the word 'Oxford' using the Yahoo and Google search engines to find any other local sources of material. All the references to UK studies were followed up, but for studies based in other countries only those which seemed particularly relevant were consulted, the main focus being on the experiences of students studying in the UK.

Some studies have suggested that the mental health of students is significantly poorer than that of the general population. A particularly comprehensive piece of research, published by Webb and colleagues in the Lancet in 1996, was based on a sample of 3,075 second year students, across 10 UK universities. The researchers achieved a response rate of 'nearly 100%'. This survey used a questionnaire on drug and alcohol use, combined with HADS. Webb et al.'s findings (1996) compared with HADS figures for the general population showed levels of moderate and severe anxiety to be significantly higher amongst students and found high levels of drug and alcohol usage (see Tables 1.1, 1.2 & 1.3). Their study was confined to universities which contained a medical school, which means that none of the former polytechnics were included in the sample, so these results may not be typical for the sector as a whole and for newer universities in particular. Other studies have found similar results but, as they were based on relatively low numbers of student respondents, have not been included in the tables presented. The majority of the sources used are from established peer-reviewed journals, official reports and publication. Studies published more than ten years before the start of the research (mid 2000) were not included in the tables. At a time when the nature of the student experience had undergone many changes, it was important to use the most up to date information available. Every attempt was made to find studies of current student populations, bearing in mind that the most recent would be based on research undertaken one or more years previous to publication.

1.1.2 Incidence of anxiety and depression

A range of surveys of student and other populations published between 1992 and 2002 showed that students scored higher on psychological symptoms or self-report measures of mental ill-health compared with the general population

Table 1.1 Incidence of neurotic disorders, anxiety and depression

General Population	<p>Amongst individuals living in private households:</p> <ul style="list-style-type: none">• 16.4% were assessed as having a neurotic disorder• 8.8% were assessed as having mixed anxiety and depressive disorder (10.8% for women, 6.8% for men)• 4.4% were assessed as having generalised anxiety disorder (Singleton et al. 2001). <p>Using the Hospital Anxiety and Depression Scale, Crawford et al. (2001) reported levels of:</p> <ul style="list-style-type: none">• 10.0% moderate anxiety• 2.6% severe anxiety• 11.4% depression – ranging from mild to severe <p>Women were reported to have significantly greater levels of anxiety than men, but no figures were given.</p> <p>Using the General Health Questionnaire (GHQ), between 260-315 out of 1,000 individuals living in the community were found to experience symptoms of common mental health problems lasting at least two weeks during one calendar year (Goldberg and Huxley 1992).</p>
Young Adults	<p>The incidence of neurotic disorders rises from around 13% for people aged 16-19, to 16% for the 20-24 age group. Figures are higher than this for all ages in the range 25-59, peaking at around 20% for the ages 45-54 (Singleton et al. 2001).</p> <p>Goldberg and Huxley (1992) state that common mental disorders peak in the middle years of life.</p>
Students	<p>In a study of 3,075 university students (Webb et al. 1996) using the Hospital Anxiety and Depression Scale:</p> <ul style="list-style-type: none">• 22.8% of male students and 27.9% of female students had scores indicating mild levels of anxiety• 17.3% of male students and 25.4% of female students had scores indicating moderate levels of anxiety• 6% of male students and 10.2% of female students had scores indicating severe levels of anxiety• 12.1% of male students and 14.8% of female students had measurable levels of depression, ranging from mild to severe. <p>Roberts et al. (1999) found that the GHQ-12 score of 360 students in London was twice as severe as the general population. Levels of student physical and mental health were significantly below population norms matched for age and sex. 29.3% of the respondents' GHQ scores were in excess of 1 standard deviation above the population mean for their age and sex. 42.4% of the respondents produced Social Functioning (SF36) scores more than one standard deviation below the population mean, compared with 16% in the general population.</p> <p>In a population study in the North-west of England (Harrison et al. 1999) students were found to be 1.78 times more likely to be prone to anxiety and/or depression (GHQ-12) than the general population.</p>

	<p>Grant (2002) in a survey of 1,620 (response rate 77%) second year students at Leicester University identified 23% who reported anxiety, phobias and panic attacks, and 40% who experienced sadness, depression or mood changes. In the same study 14% of students had scores for depression on the Brief Symptom Inventory subscales and 13% had scores for the obsessive-compulsive subscale.</p> <p>A study using the SF36 (Stewart-Brown et al. 2000) found that emotional health problems had a negative impact on the work of 49% of the sample of 1,208 students in higher education compared to 21% in general population of the same age range.</p> <p>By contrast a study of 834 Cambridge University students (Surtees et al. 2000) reported that the GHQ-30 scores of a cohort of students were only marginally higher than those of a national sample of 18-24 year olds. Over a three year period the scores for male students ranged between 3.5 and 4.2, whilst those for female students were between 4.8 and 5.9. (The scores given for the 18-24 national sample were 3.5 for males and 4.9 for females).</p> <p>A community study (Ostler et al. 2001) found students only half as likely to suffer depression as the general population. However, this was based on patients visiting GP surgeries and so may have excluded many students from the sample, as they may have been less willing to take such problems to a GP (see section 1.9 of this Chapter.</p>
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More female than male students showed signs of mental health problems in the surveys of student populations. There were also differences between home and international students. Javed’s (1989) Edinburgh based study showed that international students had a mean GHQ-30 score of 7.8 compared to 4.14 for British students¹. Post-graduate students at the University of Leicester had slightly lower stress levels compared with undergraduates (SPHP 2002) whilst at the University of Cambridge the figures for both groups were fairly similar (Surtees et al. 2000). There is less data available for the further education sector, but a survey of students in Oxfordshire colleges (SHEU 2002) found that 26% had experienced intrusive emotional or psychological problems during the current term and 46% had experienced intrusive emotional or psychological problems in the past.

1.1.3 Incidence of alcohol and drug misuse

Alcohol usage is often seen as a typical part of student life-styles and a number of studies have explored this aspect. Whilst alcohol use amongst students is higher than for the general population, male students are within the range encountered amongst

¹ The higher the GHQ score, the higher the level of distress.

young males generally, but female students appear to drink more heavily than females generally in their age group.

Table 1.2 Incidence of alcohol misuse

General Population	Amongst individuals living in private households around 25% showed hazardous drinking patterns (38% for men, 15% for women) 7.4% were assessed as alcohol dependent (11.9% for men, 2.9% for women). (Singleton et al. 2001).
Young Adults	The rate of hazardous drinking levels for men aged 16-19 was 45%. It peaked at a rate of 62% for those aged 20-24. Hazardous drinking among women aged 16-19 was 32% , and for women aged 20-24 was 29% (Singleton et al. 2001).
Students	<p>Webb et al. (1996) found that in a sample of 3,075 students:</p> <ul style="list-style-type: none">• Only 11% of respondents were non-drinkers.• Among drinkers 61% of the men and 48% of the women exceeded 'sensible' limits of 21 units per week for men and 14 for women.• Hazardous drinking (over 51 units per week for men and over 36 units per week for women) was reported by 15% of the drinkers.• Binge drinking was declared by 28% of drinkers. <p>Humphrey and McCarthy (1998) found that 44% of male students and 45% of female students drank more than the recommended units of alcohol per week.</p> <p>A study in an Oxford college (Sell and Robson 1998) found that 40% of men and 24% of women were consuming alcohol beyond the limits of safe drinking.</p> <p>At Leicester (Grant 2002) 25% of male students and 14% of female students were drinking at dangerous levels, and a further 17% of males and 31% of females were drinking at levels that could be harmful. 58% of students claimed to drink heavily at least once a month.</p> <p>A survey of students at Oxford Brookes University (Wyville-Staples et al. 1998) reported that more than half of the male students and one third of female students were regularly exceeding safe limits.</p>

Drug use is another factor typically associated with student life-styles. Overall it would seem that students are fairly typical for their age group in their use of illicit drugs, but no figures were available to indicate how many had become drug dependent.

Table 1.3 Incidence of illegal drug use

General Population	<p>Amongst individuals living in private households (Singleton et al. 2001):</p> <ul style="list-style-type: none">• 11% reported using illicit drugs in the past year• 3.7% were assessed as drug dependent
Young Adults	<p>Amongst individuals living in private households (Singleton et al. 2001):</p> <ul style="list-style-type: none">• Annual illicit drug use peaked at 37% for men at age 20-24 (compared to 32% for 16-19 age group, and 34% for 25-29 age group).• For women, drug usage also peaked in the age group 20-24 at a level of 29% (compared to 22% for ages 16-19 and 15% for ages 25-29)• 20-24 was also the age group in which drug dependence was highest at 19.9% for men and 9.4% for women.
Students	<p>In Webb et al.'s (1996) study:</p> <ul style="list-style-type: none">• 60% of the male students and 55% of the female students reported having used cannabis once or twice• 20% of the sample reported regular cannabis use (weekly or more often)• Experience with other illicit drugs was reported by 33% of the sample, most commonly LSD, amphetamines, ecstasy and amyl/butyl nitrate. 34% of these had used several drugs. <p>At an Oxford College (Sell and Robson 1998) 57% of students had used cannabis at some point in their lives and 23% were current users. Other current drug use was low, the highest category being amphetamines at 3%.</p> <p>At Oxford Brookes (Wyville-Staples et al. 1998) half of the student respondents had experience of illicit drugs and one quarter were current users.</p> <p>At the University of Cambridge (Surtees et al. 2000) roughly 30% of students had used illicit drugs (mostly cannabis) within a period of one year. Around 11% had used drugs in the previous week.</p>

These student drug use figures are all from studies conducted over five years ago and patterns of drug use change over the years. In Cambridge Surtees et al. (2000) found that the annual prevalence of illicit drug use, mostly involving cannabis, increased from 25.8% in 1995, to 28.7% in 1996 and 30.1% in 1997. The psychiatric morbidity surveys of the general population indicate a doubling in drug dependence between 1993 and 2000 (Meltzer et al.1995, Singleton et al. 2001). In the same period reported drug use had doubled in the age groups covering 16-64. However some of this reported increase may have been due to a more anonymous method of giving answers in the year 2000 survey.

1.1.4 Incidence of eating disorders

Students are of an age when eating disorders are likely, and the studies suggest that eating disorders are over-represented amongst female students.

Table 1.4 Incidence of eating disorders

General Population	The Eating Disorders Association calculated that there were 1,150,000 people in the UK population with an eating disorder, whether diagnosed or not (www.edauk.com accessed 8.8.03) a rate of approximately 2%.
Young Adults	50% of the cases of anorexia nervosa will occur in young women before the age of 20. 1% of the women aged 15-30 in the UK are estimated to have anorexia, 1% of women are estimated to have bulimia and a further 3% are estimated to have binge eating disorder (Bird 1999).
Students	Amongst 834 students at Cambridge (Surtees et al. 2000) 6% of women students reported problems with diet and eating. Doll et al. (2000) in a study of over 1,400 students (including Oxford Brookes University) found 6% of all respondents and 9% of the female students had a probable lifetime eating disorder. At an Oxford College (Sell and Robson 1998) 36% of the female respondents reported having experienced eating disorders at some point in their lives. 10% reported an existing eating disorder.

1.1.5 Incidence of suicide and self harm

Levels of suicide, although not high compared to other types of mental health problems in the student population, have been a particular cause of concern in recent years. A report by Universities UK (2002) found that there was little reliable evidence on the rates of student suicide outside of studies at the Universities of Oxford and Cambridge, but concluded that the rates were similar to those found in the general population.

Table 1.5 Incidence of suicide

General Population	Meltzer et al. (2002) in a general population survey of adults aged 16-74 found: <ul style="list-style-type: none">• 14.9% of respondents said they had considered suicide at some point in their lives. 3.9% had considered it in the last year• 4.4% said they had attempted suicide at some point in their lives. 0.5% had done so in the last year. In the four years from April 1996 the annual suicide rate in England was 10 per 100,000 people (Department of Health 2001, quoted in Universities UK 2002).
Young Adults	80% of suicides are by young men (The Samaritans 2002). Suicide is the cause of 20% of all deaths in young people (Bird 1999)

	<p>Meltzer et al. (2002) found that 5.2% of men and 8.3% of women aged 16-24 reported having suicidal thoughts in the past year. In the same age group 0.8% of men and 1.5% of women reported suicide attempts in the last year. The figures for a suicidal attempt during their lifetime were 2.7% for men and 7.7% for women.</p>
Students	<p>Sell and Robson's (1998) study of an Oxford College found that 31% of male and 35% of female students had contemplated suicide at some point in their lives.</p> <p>Despite concern about suicide amongst Oxford students, Hawton et al. (1995a) found that attempted suicide rates in the age group 15-24 years were considerably lower amongst Oxford University students than the equivalent local population. Looked at in rates per 100,000 of the population the figures show:</p> <ul style="list-style-type: none"> • 68 male students compared to 91 male residents • 178 female students compared to 261 female residents • 106 for all students compared to 165 for all residents. <p>In 84% of the student cases serious harm was unlikely to have resulted from the attempt, in the remaining 16% death was a distinct possibility.</p> <p>Of those Oxford students who did commit suicide (Hawton et al. 1995b), over a 14 year period, there was a higher rate of definite suicides than in the expected figure for the general population aged 18-25:</p> <ul style="list-style-type: none"> • 16 males against an expected 9.77 • 5 females against an expected 1.32 • 21 male and female students against an expected 11.09. <p>However, when the figures are compared taking into account undetermined deaths, the differences are not so marked:</p> <ul style="list-style-type: none"> • 16 males against an expected 14.69 • 6 females against an expected 2.35 • 22 male and female students against an expected 17.03. <p>In a two year study of over 800 Cambridge University students (Surtees et al. 2000) 93 students reported having considered suicide, 14 of these reporting actual attempts. This corresponds to annual rates of around 6% and 0.9% respectively.</p> <p>Also at Cambridge Collins and Paykel (2000) found a suicide rate that equated to 11.3 per 100,000, and a rate of 15.1 per 100,000 in overseas students.</p> <p>Suicides and deaths with undetermined causes were estimated at annual rates between 6.99 and 9.00 per 100,000 full-time students in the UK between 1994 and 1998 (Universities UK 2002).</p> <p>A study across four Higher Education institutions in the South Midlands of the UK (Doll 2000), found:</p> <ul style="list-style-type: none"> • 9% of student respondents reported having had thoughts that life was not worth living in the past term, 38.2% reported having thought this at some time in their lives • 0.2% (during the past term) and 7% (during their life) of respondents reported attempting suicide.

There was little information of the levels of deliberate self-harm without suicidal intent within the student population, but the figures available suggest that students are at greater risk.

Table 1.6 Incidence of deliberate self-harm

General Population	Meltzer et al. (2002) in a general population survey of adults aged 16-74 found that 2% said that they had carried out deliberate self-harm without suicidal intent at some point in their lives.
Young Adults	Meltzer et al. (2002) found that deliberate self-harm without suicidal intent was reported by 3.8% of the males and 6.8% of the females in this age group.
Students	<p>A study across four higher education institutions in the South Midlands of the UK (Doll 2000), found that self-harm was reported by 2% (during the past term) and 15% (during their life) of respondents.</p> <p>6% of further education students surveyed in Oxfordshire reported self-harm in the past term (SHEU 2002).</p>

1.1.6 Incidence of psychoses

There has been very little published on the incidence of what are termed the psychoses, e.g. manic depression (or bi-polar affective disorder) and schizophrenia in the student population. However, the onset of such illnesses is known to be greater in the late teen/early adult age group.

Table 1.7 Incidence of: psychotic disorders, schizophrenia and bi-polar disorder

General Population	Out of 1,000 individuals living in private households 5 were assessed as having a probable psychotic disorder in the past year (Singleton et al. 2001)
Young Adults	Singleton et al. (2001) found no statistically significant differences for age on the incidence of psychotic disorders, but they did report that they found 2 cases per thousand and below for the age groups 16-29, compared with figures of 8 to 10 per thousand for age groups 30 to 44.
Students	<p>In the 1960s Anthony Ryle (1969) estimated the incidence of such illnesses in a student population to be between 1 and 2%.</p> <p>The Office for National Statistics Report (Meltzer et al. 1995) found that adults with GCE A-levels or higher qualifications had a much higher level of incidence of ‘functional psychoses’ at 10 per thousand for men and 8 per thousand for women, compared to the rate in the adult population of 4 cases per thousand.</p>

1.1.7 The mental health of students: a summary

Whilst it is difficult to make generalisations on the basis of such a diverse range of studies we can see that, despite their academic success, students do not seem to enjoy better mental health than the general population, and on average almost certainly suffer greater psychological distress. Compared with the population matched for age, students tend to show symptoms of higher levels of anxiety and depression. Female students show higher levels of distress than male students. Female students seem more prone to eating disorders and excessive drinking than other females in their age group. Students appear no less likely to experience psychotic conditions or to attempt suicide than the general population.

1.2 Mental health and illness: concepts and terminology

Many of the studies reviewed in the previous section of this chapter are based on an assumption that mental health and illness are objective states which can be measured. Many terms are used for what seem to be aspects of the same phenomenon: mental illness, mental ill-health, mental disorder, mental health problems, madness, insanity, psychological disturbance, abnormal psychology, psycho-pathology etc. At a more detailed level, terms such as 'depression', 'anxiety' and 'schizophrenia' are used as if there is general agreement as to what they mean and who could be said to have such conditions. Whilst positions may not be as polarised now as in the 1960s and 70s when authors such as Laing (1967) and Szasz (1961) were attacking medical orthodoxy, there are still many interpretations of mental health and illness. Perhaps it is this lack of agreement which results in the confusing terminology surrounding mental health and illness.

For the purposes of this research it is important to be clear which students experiencing difficulties come within its scope, and this is affected by whether a narrow or broad definition of what constitutes a 'mental health problem' is adopted. The World Health Organisation's definition of mental health is that it is:

... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

(WHO 1999)

Taking this definition, people could be said to have mental health problems when their state of well-being is affected to the extent that they find it difficult to perform the above functions. This is a broad definition that could encompass a large number of people, many of whom will not present themselves to helping services or even consider the need for self-help measures. Perhaps the definition is too broad, as much of it could apply to whole communities of people e.g. those living in areas of mass unemployment. In practice, qualitative research which asks respondents for their experience of supporting people with mental health problems or illnesses relies to a large extent on how they interpret these terms, either from a lay or professional perspective.

Rogers and Pilgrim (1997) found that lay people were much clearer about what constituted physical health and mental illness than what was meant by 'mental health'. In fact the word 'mental' whether followed by 'health' or 'illness' was seen in negative terms. The authors suggest that the terms 'emotional' or 'psychological' health may be perceived as less stigmatising. In some cases schizophrenia was seen as a mental illness, whilst depression was not. Where respondents were able to describe 'mental health' it was seen as not so much about happiness or contentment, but rather about being rational and being able to cope with everyday life. Significant differences in public and professional beliefs about mental health problems and their treatment have been found. Lay people are more likely to prefer self-help and psychological measures in preference to treatment with medication (Jorm 2000).

Whilst many people may either feel mentally 'ill' or score high on measures of psychological distress, the work of Goldberg and Huxley (1980, 1992) shows that the practice of GPs, psychiatrists and other health professionals is critical in deciding whether or not they are recognised as having a mental illness. These professionals tend to be looking for distinctive clusters of symptoms which enable a formal diagnosis to be made (Tyrer & Steinberg 1999). Such diagnoses are listed in The World Health Organisation's (WHO 1992) *International Classification of Disease – 10* and the American Psychiatric Association's (1994) *Diagnostic and Statistical Manual of Mental Disorders IV*. Thus, at a pragmatic level, a mental illness is any condition that is recognised (or capable of being recognised) as such by a medical professional (Goldberg & Huxley 1980). Inevitably the boundaries of who is included or excluded from diagnosis will change. In the last few years there has been debate on whether people with 'personality disorders' should be seen as mentally ill (Eastman 1999). In the 1950s and 60s students at Oxford University were receiving psychiatric treatment

for homosexuality (Davidson & Hutt 1964), at the time both illegal and considered to be a form of mental illness. Questions have also arisen about possible cultural misunderstandings in the diagnosis of mental health problems in different ethnic groups (Pilgrim & Rogers 1999).

Psychologists and psychotherapists are another group with professional views on what constitutes mental, emotional or psychological health. As psychology is concerned with understanding aspects of everyday or so-called 'normal' functioning, the study of abnormality, dysfunctionality or pathology is just one strand of the discipline. Psychologists are as likely to be interested in the qualities of those who cope well. For example, the benefits of promoting 'emotional intelligence' have recently come to popular attention (Goleman 1995).

Cross-cultural psychology suggests that there are many ways of viewing mental health and illness (Warner 1996). Warr (1987) acknowledges that mental health is difficult to define, but states that from a Western perspective it can be seen as a continuum with health at one end and ill-health at the other, with most people falling in the middle on a normal frequency distribution. Warr sets out five major components of mental health: affective well-being, competence, autonomy, aspiration and integrated functioning. From a psychological perspective then, mental health is about more than just feeling happy. A person's mental health becomes a concern to themselves or others when there is 'significant suffering and/or maladaptive functioning' (Glassman 2000, 393). This psychological interest in a range of mental health states may be contrasted with psychiatry which is more concerned with detecting and treating mental illness.

Measures of psychological well-being and distress, such as the General Health Questionnaire (GHQ), have cut-off points beyond which a clinical intervention may be necessary. These cut-off points are based on studies of psychiatric populations, but their placing is inevitably somewhat arbitrary. There will be people who are just above or below the line but whose ability to cope with their distress may vary enormously. As discussed later in this chapter, certain approaches tend to favour a distinction between mental health and mental illness (e.g. a medical or biological approach), whereas others (e.g. a humanistic psychological approach) prefer a continuum approach to mental health and illness.

The ability to function in acceptable ways is a significant factor in some definitions of mental health. A report by the Heads of University Counselling Services,

(Rana et al.1999) describing the increasing level of ‘psychological disturbance’ amongst students, refers to the notion of functioning when it explains that:

The term ‘psychological disturbance’ is used here to encompass a wide range of problems, including psychiatric illness, behavioural disturbance and psychological and social difficulties, which may seriously and adversely affect the ability of students with such problems to pursue their studies adequately.

(Rana et al. 1999, 1)

Different groups will use and perceive terms such as ‘mental health’ and ‘mental illness’ differently. For the purposes of this research a broad definition of the term ‘mental health problems’ has been adopted encompassing diagnosable ‘mental illnesses’ as well as levels of emotional distress which affect a person’s ability to function personally, socially and academically. However, it is important to recognise that research respondents will have their own interpretations of these various terms.

There is no cognitive correlate that shadows in our minds the speaking of the words. The idea that the true nature of ‘mental illness’ can be discovered there, like a pot of gold at the end of a rainbow, must be abandoned. Instead, meaning is its use. Its meaning is displayed by the context of its deployment, verbally and socially.

(Bowers 1998, 146)

1.3 Approaches to mental health and illness

Mental disorders can be studied at two levels: from the standpoint of knowledge about how the brain works, or from knowledge about how man behaves as a social animal.

(Goldberg & Huxley 1992, 1)

The support that anyone presenting with a mental health problem will get in a particular situation will depend on what are considered to be the causal factors of mental health problems, and the appropriate response to these. Models that account for the normal range of mental functioning and those focused on mental illness/disorder tend to be based on similar theoretical foundations. Glassman (2000) lists the mainstream approaches to the study of human psychology as: biological, behaviourist, cognitive, humanistic and psychodynamic. Similarly, when accounting for mental disorder Tyrer and Steinberg (1999) describe social, psychodynamic, cognitive, behavioural and biological models.

A series of articles in the British Medical Journal (Bracken & Thomas 2001, Baker & Menken 2001) on social and biological aspects of mental health stirred up a lively correspondence amongst service users, researchers and practitioners alike,

indicating that the long-running debate about the causation of mental health problems is far from resolved, despite advances in the study of the biology of the brain. A recent publication (Read et al. 2004) makes a comprehensive attack on biological explanations for schizophrenia setting out the case for psychological and social explanations.

The diversity of models of mental health/illness and how they are translated into practice offers interesting possibilities for research. It is possible to ask how mental health problems are viewed by key players in the students' lives and by the students themselves and to explore how this affects the nature of support offered. Whilst it is beyond the scope of this thesis to catalogue and describe every theory of, and mode of treatment for, mental health problems, it is possible to identify some broad headings typifying different approaches which may be encountered.

Tyrer and Steinberg (1999) provide one framework for both interpreting existing findings on student mental health and conducting new research. The authors propose that a person's mental health can become disordered at one or more of five levels which form a hierarchy: social (social and psychological interactions), psychodynamic (feelings and emotions), cognitive (thinking), behavioural (actions), and culminating in the biological (disease) level. Each of these levels corresponds to a 'model of mental disorder' which has accompanying interventions. Although the triggering event may be at a particular level, e.g. losing one's job (social level), the resulting disorder and appropriate response may be at a different level e.g. severe depression (disease level). Each of these models is seen as complementing each other, so that the most effective response to mental disorder is to diagnose the level at which the person is affected and treat them with interventions at that level and below. Therefore we should avoid the situation where:

... rigid adherence to one of the standard models leads to a blinkered view of mental disorder that hinders the multidisciplinary approach that is such an important part of good practice.

(Tyrer & Steinberg 1999, foreword)

Whilst there is much of value in Tyrer and Steinberg's formulation of different models of 'mental disorder' and their relationship to each other, it is not without its problems. The separation of cognitive and behavioural elements does not correspond to current thinking and practice, which tends to combine the two. In fact there is confusion within the authors' own work. On page 119 of their book Level 3 is cognitive and Level 4 is behavioural; on page 121 this order is reversed. The case studies in the book suggest that the preferred order is:

social → psychodynamic → behavioural → cognitive → disease

However, either order is possible depending on which section of the Chapter you read. I contacted one of the authors, Peter Tyrer, for clarification and got the following reply:

Thank you for pointing out the inconsistency. It is fair to say in practice that cognitive and behavioural models are probably interchangeable but in our original draft we put the behavioural model above the cognitive one.

(Peter Tyrer e-mail dated 15.8.00)

Given this it would seem simpler to follow the practice of many other authors and have one broader category which embraces both behavioural and cognitive factors.

Feltham (2000) outlines four broad approaches to counselling and psychotherapy: psychoanalytic, cognitive-behavioural, humanistic and 'other'. Dallos (1996) describing psychological approaches to 'mental health and distress', also lists humanistic psychology as a separate category the others being: biological /medical, behavioural (including cognitive), psychodynamic and systemic (family systems). Carr (2001) proposes a set of four models of 'abnormal behaviour': biological, psychoanalytic, cognitive-behavioural and family systems.

Looking more specifically at certain conditions, Newton (1988) identifies theories accounting for depression: psychoanalytic, psychological (cognitive and behavioural), biological, psychosocial and psycho-evolutionary, and mentions biological, psychological and psychosocial theories in relation to the causes of schizophrenia. Clare (1980) outlines three models of severe mental illness: organic, psychotherapeutic and sociotherapeutic.

Whilst a number of authors (Carr 2001, Dallos 1996, Feltham 2000, Glassman 2000, Newton 1988) describe a range of approaches to mental health/illness, Tyrer and Steinberg go beyond this to discuss how these different approaches might interact or be integrated. Dallos recognises that while there are clear differences between approaches:

...there are important features that they share, especially in the 'messy' business of clinical practice where many practitioners use an eclectic and pragmatic approach.

(Dallos 1996, 13)

It seems that more attempts have been made to refine different mental health theories and interventions rather than to fit them together. Most explanations of aetiology and descriptions of possible interventions can be grouped within three main categories:

- Social, including radical, psychosocial and systemic models
- Psychological, including cognitive, behavioural, psychoanalytic/psychodynamic and humanistic models
- Medical, including biological, genetic and disease models.

Each of these represents a particular focus on mental health and illness and in some cases is associated with a particular profession e.g. social work, clinical psychology or psychiatry.

1.4 Social approaches to mental health and illness

Most mental illness is diagnosed on the basis of an individual's behaviour and their reported patterns of thinking and feeling, and not on the results of physiological tests. As a result the subject has been open to many competing theories concerning its causation, its meaning and what constitutes an appropriate response. The fact that a condition such as homosexuality was once illegal and considered to be a mental illness in the UK demonstrates that the social context must be taken into account (King et al. 2004).

Radical views deny that there is such an entity as mental illness, seeing it as a label attached to behaviour which deviates from society's norms. Another view accepts that mental illness exists, but sees its causes as being social, not biological. A third states that there is a biological element to mental illness, but sets out to show that social factors are also significant in its onset and progression. Others are less concerned with causation than with demonstrating the positive effect of social support.

Much of the debate on the nature of mental health problems has centred around schizophrenia, although there are far fewer people diagnosed with this condition than with affective/ neurotic disorders. Perhaps this is because much of the work of psychiatrists is taken up with psychotic disorders (Wessley 1996). It may also be that, from a lay person's perspective, such conditions are less easily understandable as a reaction to life events than are conditions such as anxiety and depression (Rogers & Pilgrim 1997).

1.4.1 Radical social models

The radical psychiatry views of the 1960s and 1970s influenced by R.D. Laing and others reflect a social approach where schizophrenia could be seen as not as an organic illness but as a response to the person's situation:

... it seems to us that without exception the experience and behaviour that gets labelled schizophrenic is a special strategy that a person invents in order to live in an unliveable situation.
(Laing 1967, 95)

Laing took the view that psychotic experiences were a journey that the individual needed to make in order to make sense of the world. Being medicated and institutionalised would only prevent the person from completing that journey and serve to maintain their career as a patient rather than as an individual participating in society. These ideas were put into practice through the therapeutic communities formed by the Philadelphia Association. However, the association of Laing's ideas and others, such as David Cooper and Aaron Esterson, with other radical agendas and elements of 1960s and 70s mysticism probably helped to limit its impact on mainstream psychiatric practice (Coppock & Hopton 2000).

Whilst Thomas Szasz (1961, 2001) has also been associated with the 'anti-psychiatry' movement of that era, he differed from Laing in his fundamental views of mental illness. Szasz approached mental illness from a right-wing libertarian perspective and did not believe that mental illness was an illness. He opposed state intervention:

If disease is defined in materialistic terms then, from a logical and scientific viewpoint, there can be no such thing as mental illnesses. Accordingly, I suggested more than 40 years ago, that mental illness is a myth (the behaviours called mental illnesses are not diseases). ... I fear we are in the process of building a therapeutic state – a modern, scientific totalitarianism, resting on replacing democratic-political governance with pharmacratic-bureacratic regulation.

(Szasz 2001)

One of Szasz's arguments is that mental illness is a label applied to behaviour that society cannot accept. This view is echoed in sociological views of deviancy, rule-breaking and labelling, which tend to bracket mental illness with criminality, political unrest and other forms behaviour which challenge social norms. The work of Erving Goffman (1961) and others set out to show how the creation of the role of the mental health patient led to the performance of certain behaviours that might be quite unrelated to any underlying 'illness'. Whilst this concept has been accepted for understanding the secondary impact of institutionalisation and stigmatisation of those who use mental

health services, recent writers (Bowers 1998, Pilgrim & Rogers 1999) have concluded that labelling and rule-breaking theories are not satisfactory explanations for the primary existence of mental illness.

1.4.2 Social models of causation

Lucy Johnstone (2000) argues that there is no convincing evidence for the biological basis of mental illness. She believes that 'mental illness' is a description of behaviours which often appear strange and sometimes threatening, but which can be accounted for in terms of reactions to the social world. Johnstone tends to refer to mental or psychiatric 'breakdowns' rather than illnesses. Coppock and Hopson (2000) also speak of

... those forms of mental distress for which there is no unambiguous evidence of biological or bio-chemical causation. These include psycho-neuroses, affective disorders, schizophreniform disorders, personality disorders and eating disorders such as bulimia and anorexia nervosa.

(Coppock & Hopson 2000, 149)

Some mental health conditions may be purely social in origin, but Bowers (2001) points out that it is never going to be possible to rule out a physiological cause even if one has yet to be found. In the end the debate may focus less on what causes the various forms of what we call 'mental illness' or 'disorder', but more on how we treat them. Although social causation has yet to be proved, there is much evidence of social factors influencing mental health problems.

1.4.3 The influence of social factors

Tyrer and Steinberg's (1999) social model of mental disorder focuses on how stressful life events and circumstances, such as poverty, job loss or changes in living conditions, can trigger mental disorder. The authors acknowledge the role of society in defining mental disorder and discuss how this affects the psychiatrist's role. Treatment within their social model is intended to help the individual take up an 'acceptable role' in society. Beyond treatment, they suggest action can take place at the societal level to change attitudes.

Increasingly writers have acknowledged that social factors play a part in the way that mental illness is presented or detected in a population. There is strong evidence that the incidence of mental illness varies between social classes (Pilgrim & Rogers

1999) and that the incidence of depression is affected by life events (Brown 1996). Unemployment is associated with poorer mental health (Singleton et al. 2000). Recovery rates from schizophrenia are much higher in the developing world (Glassman 2000). All of these examples have been used to suggest that there is a social dimension to mental health.

Anti-psychiatry is being replaced with 'post-psychiatry' (Bracken & Thomas 2001) and by psychosocial approaches (Bebbington 1991) which acknowledge that the disturbed individual cannot be viewed in isolation. Whilst biological abnormalities are cited as the cause of mental health problems in the disease model, attention has also been focused in the reverse direction. Life experiences have been shown to affect the biological development and functioning of the brain (Kandel 1998, Gabbard 2001). John Wing is typical of many writers in concluding that:

... social models of psychiatry that exclude any biological element are as unsatisfactory as biological models that exclude any social content. Both types of exclusivity tend towards tautology or triviality and both can be disastrous in practice.

(Wing 1991, 9)

Both Goldberg and Huxley's (1980) stress-diathesis model and Cochrane's (1983) development and reappraisal of that model are examples of earlier attempts to give social factors a place.

In his review of the 'social nature of mental illness' Bowers (1998) concludes that despite cultural and historical variations, there is an 'unyielding core' of a phenomenon which can be described as 'mental illness' and that we should not get drawn into semantic debates about the nature of illness. Rather, sociological approaches could usefully explore the psychosocial processes involved, the ways in which psychiatrists and others distinguish between normal distress and mental illness, and how the stigmatisation of mental illness can be challenged.

1.4.4 Social approaches to treatment and support

Certain approaches to treatment and support may be termed 'social' in that they are concerned to promote social integration and inclusion, to develop the person's social skills, and use social settings to promote recovery or good mental health. Such approaches have been termed 'social therapy' (Milne 1999) when explicitly promoted by professionals to improve the capacity of a community or family to support someone with mental health problems. It is easier to maintain a person's social network than to

rebuild it after it has fallen apart, but this will not be seen as a priority unless social factors are taken into account (Onyett 1992). The importance of a stimulating but not too stressful social environment in reducing social withdrawal and countering negative symptoms for people with schizophrenia has become widely accepted (Birchwood & Jackson 2001). Support mechanisms developed within community services and the voluntary sector to facilitate employment and socially-valued roles (O'Flynn & Craig 2001) are consistent with this approach.

1.4.5 Social approaches to students' mental health

Many authors have stated that both social and psychological awareness of the student's situation is needed (Earwaker 1992, Ryle 1969). At a macro level social factors could include the nature of the university or college's cultural environment, the status of students in society, or their economic and residential situation. At a more immediate level social explanations may take into account exam pressure, the level of work expected of students, the effects of debt (Roberts 1998, 1999), and the level of social support available.

Entering university is usually the first step away from the parental home and with it come disturbances to social support, to eating and sleeping patterns, to social and sexual pressures, on top of the demands of sustained intellectual work. It is a time of both physical and emotional transition and, as such, many of the psychosocial disturbances that are picked up by psychiatric assessment may be no more than a 'normal' response to such transitions rather than any actual morbidity.

(Firth-Cozens 1987, 8)

As students depend so much on their intellectual abilities on a daily basis, even short term distress can have a major impact on their work, leading them to get behind schedule, causing in turn secondary anxiety and depression (Malleon 1978).

In many cases students are cut off from their social support networks at home and have to build new ones. Perceived social support is a significant predictor of psychosocial adjustment. Halamandaris (1995) found that students who did not form relationships in the first two weeks of term differed significantly from those who did in their personality and levels of well-being. The perception that social support is available is related to feelings of well-being for an individual, whereas as the perception of having been the recipient of social support is not (Newland & Furnham 1999, Bolger et al. 2000).

Changes in the nature of higher education may have weakened social support. Increasing numbers of full-time and part-time students without an accompanying rise in staffing have depersonalised the academic environment, requiring students to work more independently. Teaching staff are more distant figures, harder to access. With the Research Assessment Exercises there has been a pressure on staff to increase publication rates, and in many institutions academic staff are required to generate income (Rana et al. 1999). The introduction of modular degrees in many institutions has led to further anonymity, with the loss of stable peer groups for students and less continuity (Rana et al. 1999, Thompson 1998). The oldest universities have not been as affected by these changes and have much closer social networks within the collegiate system. However, some students can still feel isolated. Whilst many students were found to be enjoying their life within a college at the University of Oxford:

... this general aura of well-being could make the plight of the small number of individuals suffering serious emotional disorder or swamped by distress seem all the more crushing.

(Sell & Robson 1998)

Perhaps the most stressful aspect of the academic system is perceived to be examinations. Students' levels of anxiety and obsessionality rise in the months before examinations, whilst levels of depression increase in the period after the exams before the results are known (Fisher 1994). At Cambridge University (Surtees et al. 2000) 6.8% of students reported their degree courses as extremely stressful in 1995, rising to 12.2% and 12.0% in 1996 and 1997. Twice as many women as men reported their degree courses as extremely stressful at each of the three assessments. Psychological morbidity appeared to peak at times coinciding with university examinations. Rutter and Smith (1995) suggest that the increasing number of young people in further and higher education, experiencing exam stress and academic failure, may be one factor linked to an increased occurrence of psychosocial disorders in this age group.

A survey of students in Dublin (Tyrell 1992) found that academic issues were the most frequently cited sources of stress, but money and relationship problems were also significant issues. Stewart-Brown et al. (2000) reported that the main cause of students' emotional distress appeared to be problems with study, work and money. At Cambridge University (Surtees et al. 2000) around one third of students reported academic problems as giving either 'quite a lot' or 'a great deal' of worry with financial and social/personal relationship problems also relatively common.

The link between student debt and psychological disturbance has been highlighted in recent studies. Poorer mental health amongst students was related to longer working hours outside university, difficulty in paying bills, and having considered dropping out of university. Students who were in debt were found to be more likely to know students who were involved in prostitution, crime or drug dealing in order to help support themselves financially (Roberts et al. 1998, 1999, 2000). Students' anxiety and depression were significantly correlated to anticipated levels of graduate debt (Stradling in Scott et al. 2001). Olohan (2002) is more cautious about making this link, suggesting that there are many aspects of the academic, social and residential environments that can have an adverse impact.

Students are not a homogenous group and the factors which impact on mental health vary among them. Three significant groups in terms of numbers are: international students, mature students and graduate students. There is a limited amount of published research on their mental health.

Issues of cultural difference have been found to affect international students' psychosocial adjustment to university life. International students have significantly more problems with adjustment than British students (Javed 1989, Halamandaris 1995, Bradley 2000). It seems that contact with the host culture and prolonged absence from home are significant factors. One study (Halamandaris 1995) found that at two weeks after arrival at university, non-home students were more positive about themselves and less neurotic than the home students. However, at the start of the second semester, non-home students were less well adjusted than home students.

International students may experience significantly more challenging life events and difficulties than British students, with a significant impact on their mental health and well-being. Javed (1989) reported that 31.3% of international students experienced the presence of threatening events compared to 7.3% of British students, and reported more problems relating to academic stresses, accommodation issues, financial difficulties and relationship difficulties than home students. Many international students experienced difficulties in adjusting to the methods of teaching and instruction encountered in the UK, had significantly fewer close friends in their university city and less social support in general. This was correlated with symptoms of anxiety and depression. Overprotection by both parents and low levels of maternal care were significantly associated with problems of social adjustment in international, but not British, students (Javed 1989).

Whilst older students may bring experience and maturity to their studies, married and mature students found meeting the demands of course-work particularly stressful (Monk 1996, Monk & Mahmood 1999). For full-time mature students in long-term committed relationships, partner support is very important, but this support tends to decrease over a period of time (Norton et al. 1998). A source of tension may be that the mature student is changed by their experience of education, or wants to change, and this is not welcomed by their close family (Bell 1996).

Walters (2000) suggests that one motivating factor for being a mature student is to compensate for past wounds and disappointments, so that the educational process is akin to a therapeutic experience for such students. These students may well bring existing psychological problems with them (Lago 1999), but there is a lack of research which quantifies any differences between the mental health of mature and other students.

Although Collins (2000) found an indication of a higher rate of suicide amongst male post-graduate students compared with male undergraduates, there is little research comparing the mental health of these two groups. Postgraduates at Leicester scored slightly higher for obsessive-compulsive symptoms, but otherwise showed somewhat lower levels of mental distress than second year undergraduates (SPHP 2002). A study at Cambridge University (Surtees 2000) found that more post-graduates than undergraduates reported the existence of a confiding relationship (a factor found to promote mental health), but they were just as likely to approach the university counselling service. One factor motivating students to continue with post-graduate study may be to delay the final stages of adult development. If students are aware of this it can be healthy, giving them the time they need, but some are not aware and find difficulties in completing their work (Bell 1996).

1.5 Psychological approaches to mental health and illness

Although many psychological/psychotherapeutic approaches have been developed over the years, there are some key approaches which are used within UK counselling and psychotherapy provision. Historically, psychoanalytic approaches were the first to emerge, starting with Freud in the late 19th century. Person-centred approaches began in the 1940s with the work of Carl Rogers. Behavioural therapy

started to be used in clinical work in the UK in the 1950s, whilst cognitive approaches started with the work of Beck in the 1960s. (Palmer 2000, Dryden 1996). By the 1980's these latter two approaches came together in the form of Cognitive Behavioural Therapy (Hawton 1989). Family systems approaches were developed in the UK during the 1960s and 1970s (Skynner 1989). Cognitive Analytic Therapy came into being in the 1970s and 1980s (Ryle 1982).

The inclusion of psychotherapeutic treatments within the services offered by primary and secondary care in the UK has highlighted differences of opinion on the role of biology in mental functioning (Pilgrim 1996). Wessely (1996) has pointed to the trend for 'non-psychotic mental disorders' (e.g. anxiety and depression) to be treated by 'non-directive counselling', with psychiatry becoming increasingly focused on chronic psychotic conditions. With psychotherapy and counselling being used as adjuncts to medical services, there have been calls for evidence of the effectiveness of these treatments (McLeod 2000). Roth and Fonagy's (1996) '*What works for whom: a critical review of psychotherapy research*' arose from research commissioned by the UK's National Health Service Executive to evaluate the evidence for some of the major forms of psychotherapy available. The authors comment that:

... most recent outcome investigations concern themselves with treatment approaches clearly nested within the theoretical framework of one of these orientations. Less is known about the value of combining orientations, even though this might be more representative of everyday practice.

(Roth & Fonagy 1996, 4)

The collection of reliable evidence on the effectiveness of any one psychological treatment is complicated by the tendency amongst practitioners to combine different approaches, as well as other variables including the skills, the level of training and the personality of the practitioner. It is also likely (Glassman 2000) that the quality of the relationship and the client's belief in the efficacy of the treatment are significant factors. Whilst Roth and Fonagy ask 'what works for whom?', what they are really addressing is which approaches suit which mental health conditions. It is possible that clients' personality variables are a significant factor in the suitability of a particular psychotherapeutic treatment for a particular individual. All these factors make it difficult to assert that some psychological approaches are more effective than others. Nevertheless, research is being undertaken which attempts to find outcome evidence for the effectiveness of counselling and psychotherapy, an example being the CORE system developed at the University of Leeds (Mellor-Clark 2000).

Malleson (1978) was one of the earliest writers (starting in the 1960's) to suggest that study difficulties may reflect psychological disorder. He warned that these difficulties can be compounded by academic staff's frustration and annoyance with students whose work is affected by psychological problems and by the students' own reactions to the situation. Similarly Ryle believed that there had been a change in the way that students' problems are labelled:

Students, who in the old days would have been regarded as stupid, lazy, undisciplined, or undecided, may, with the existence of health services, be diagnosed as suffering from emotional or neurotic disorders.

(Ryle 1972, 214)

The psychological explanations offered for students' mental distress range across both personal vulnerability factors and their interactions with the academic environment. Most psychological approaches tend to view mental health as a continuum and, as we have seen, much of the research does not tell us how many students are psychiatric 'cases', but rather indicates that a significant proportion of the student population have measurable psychological distress.

1.5.1 Cognitive and behavioural approaches

Some writers (e.g. Feltham 2000, Carr 2001) consider cognitive and behavioural approaches to be in the same category, whilst others (e.g. Tyrer & Steinberg 1999, Glassman 2000) treat them as separate. In practice, particularly within NHS funded services, cognitive and behavioural elements tend to be combined within particular therapeutic approaches e.g. Cognitive Behavioural Therapy (CBT). Cognitive Analytic Therapy (CAT) will be considered as a separate approach, as it combines both cognitive and psychoanalytic elements.

The behaviourist approach has typically focused on observable behaviour rather than the inner workings (thoughts and feelings) of the mind. Normal or abnormal behaviour is learnt through experiences which either reinforce or discourage certain actions. Tyrer and Steinberg outline the central tenets of the behavioural model as applied to mental health problems:

Symptoms and behaviour constitute the main features of mental illness

The origin and persistence of the symptoms of behaviour can be understood through the science of learning theory

The application of learning theory removes maladaptive symptoms of behaviour and, in so doing, cures the disorder

(Tyrer & Steinberg 1999, 55)

The behaviourist approach has been criticised for dealing with symptoms rather than underlying causes, and for being potentially manipulative and controlling. However, it also has positive features such as producing observable and measurable results, employing fairly simple techniques and not accepting diagnostic labels as a barrier to change. Whilst behaviourist techniques are used to treat certain conditions e.g. systematic desensitisation for phobias, they are not usually considered sufficient for the wider range of mental health problems (Coppock & Hopton 2000).

The cognitive approach is founded on the assumption that behaviour cannot be adequately explained by stimulus and response alone. Between the stimulus and the response is a mediator, the thinking process of the individual, which organises information within an internal cognitive map (Glassman 2000). Also considered are factors such as attitudes and cognitive dissonance where people experience internal conflicts between certain of their attitudes. Attribution theory, developed by Fritz Heider (Glassman 2000), explains thoughts and actions in terms of the interpretation that the individual places on their experiences. Richard Lazarus' cognitive appraisal theory (Glassman 2000) emphasises the links between cognitive interpretations and emotional responses.

Tyrer and Steinberg see the main features of the cognitive model (in relation to mental disorder) as follows:

People's view of their world is determined by their thinking (cognition)

Cognition influences symptoms, behaviour and attitudes

Impaired (dysfunctional) cognition creates mental pathology

Significant change in mental disorder needs to involve significant change in cognition.

(Tyrer and Steinberg 1999, 75)

Whilst the cognitive approach may be considered to offer more insight to the client than a purely behavioural approach, those from a psychoanalytic background may feel that it takes insufficient account of the role of the unconscious. However, the gap may not be as large as is suggested. Despite Tyrer and Steinberg's emphasis on thinking, the cognitive approach acknowledges that 'mediational processes of *some* kind underlie *all* behaviour.' (Glassman 2000, 191).

1.5.2 Cognitive-Behavioural Therapy (CBT)

Cognitive-Behavioural Therapy has developed from the cognitive and behavioural traditions and is widely used within NHS services.

The basic premise of cognitive therapy is that the way an individual feels or behaves is largely determined by their appraisal of events.

(Szymanska & Palmer 2000, 57)

The treatment is very much in the present and although it is useful to know where thoughts, feeling and behaviours came from, the main concern is what reinforces them now and how they could be changed (Hawton 1989). Psychological problems may occur through negative life events, social and economic stressors and poor coping strategies (Szymanska & Palmer 2000). One of the key purposes of the therapy is to help someone look at their self-defeating beliefs or automatic thoughts (also termed ‘thinking errors’) which they may until now have accepted as given. Cognitive-Behavioural Therapy has been described as:

... a purposeful attempt to preserve the demonstrated efficiencies of behaviour modification within a less doctrinaire context and to incorporate the cognitive activities of the client with efforts to produce therapeutic change.

(Kendal P & Hollon S 1987, 1)

Hawton et al. (1989) provide guidance on a number of conditions for which CBT is used: anxiety states, phobias, obsessional disorders, depression, somatic problems, eating disorders, chronic psychiatric handicaps, marital problems and sexual dysfunction. Szymanska and Palmer (Szymanska & Palmer 2000) add chronic fatigue, schizophrenia, post traumatic stress disorder, substance abuse problems and personality disorders to the list.

Carr (2001) reviews the evidence for CBT and says that it can be as effective as antidepressant medication for relieving the symptoms of depression and more effective at preventing relapse. According to Carr many cognitive-behaviourists reject the notion of schizophrenia as a disease.

Rather, psychotic experiences are viewed as being on a continuum with normal experiences. Thus delusions are not meaningless, but are strongly-held irrational beliefs, the formation of which has been influenced by cognitive biases...

(Carr 2001, 121-122)

1.5.3 Cognitive approaches to students' mental health

Cognitive approaches suggest an investigation of unhealthy patterns of thinking and behaviour developed by the student, and of their personality traits. Such approaches are also relevant to students' appraisal of their situation and their reactions to stress.

Homesickness is often a concern in student populations. Fisher and Hood (1987) compared students living at home and those who took up university accommodation but found no significant difference in psychological disturbance between the two groups. However, both groups showed a rise in psychological disturbance (they were tested both before and after starting at university), suggesting that it was the university experience, not residential status, that was the cause of stress. In another study the same researchers (Fisher & Hood 1988) concentrated on residential first year students and found that the 31% who reported themselves as 'homesick' had raised levels of anxiety, depression, phobias, obsessions and somatic symptoms. A comparative study between a UK university and one in the Netherlands (Stroebe et al. 2002) found evidence that homesickness preceded depression and psychological distress, and hypothesises that students were undergoing a grief reaction. Homesickness can also be considered in a psychodynamic way, looking at issues of attachment and adjustment (Rana 2000). If young adults are taking longer to achieve emotional maturity and physical separation from their parents (Apter 2001) homesickness could be a manifestation of this situation.

If homesickness is linked to low levels of perceived social support, this may be a result of a tendency for psychologically disturbed individuals to form lower quality social networks (Newland & Furnham 1999). Personality factors such as neuroticism, extroversion, self-esteem, social inhibition and perceived social competence, as well as the holding of dysfunctional attitudes may affect students' abilities to form supportive networks and their psychosocial adjustment to university (Halamandaris 1995).

Expectations prior to joining university or college which differ from the reality of the student experience have been identified as a stressful factor. Students found a lack of sufficient information about course and assessment details to be stressful. This is important because perceived stress is a significant predictor of overall adjustment to university life (Thompson 1998). A Canadian study (Pancer et al. 2000) found that students who had experienced low levels of perceived stress prior to entry to university showed relatively good adjustment, whereas students who had experienced high levels

of stress prior to entry showed relatively poor adjustment when their expectations about the transition were simple, but better adjustment when their thinking was more complex. Students who had discussed university life with parents and others prior to entry had more complex expectations and greater levels of information about it. These students experienced lower stress levels once at university than did those with less information. This has particular significance in the context of widening participation, as there are growing numbers of students whose families have no prior experience of higher education.

Personality variables were studied by Furnham & Mitchell (1991) using occupational therapy students at Dorset House in Oxford. They found that assertiveness and an internal locus of control were associated with academic success. Whilst many factors impacted on academic success, neuroticism was found to have some negative effect on achievement. In another study, students reported academic problems which tended to focus on personal and intellectual insecurities (Grayson et al. 1995). These feeling of insecurity were partly sustained by the incorrect belief that other people did not experience the same feelings. Whilst some school pupils would not achieve a place in higher education owing to the effect of neurotic symptoms, others might have neuroses which, academically at least, could be 'efficiency promoting' (Malleon 1978). Such children studied at the expense of forming relationships and participating in a balanced range of activities. Whilst they may have survived within the school system, they could find the experience of higher education destabilising. Research in the USA (Rice et al. 1998) suggested that perfectionism in students could have adaptive and maladaptive dimensions, and that the maladaptive dimensions were associated with a range of psychological difficulties.

Students' choice of subject may be linked to their patterns of thinking. There has been some evidence that Arts students showed more signs of psychological disturbance and tended to have had poorer paternal relationships than other students (Springett et al. 1986), indicating that some sort of 'psychological pre-selection' was taking place. The researchers suggested that the basis of this pre-selection may have been an interconnectedness between the clarity of identity, cognitive style and educational preferences of adolescents. Arts students might show more symptoms of 'identity confusion', including poorer relationships, primarily with fathers. Payne (1978) refers to Hudson's work in the 1960's on the differences between schoolboys who either chose or were good at science subjects, and those who preferred arts subjects. Those on the science side:

... tended to have a high IQ on intelligence testing, to be obsessive, able to focus exclusively on their work, compliant, and to have a low standard of general knowledge.

(Payne 1978, 72)

Whereas those who favoured the arts subjects that might be linked to creativity:

... had a much lower IQ measured by intelligence tests, tended to be scatter-brained and non-conforming, and had a high standard of general knowledge.

(Payne 1978, 72)

1.5.4 Psychoanalytic/psychodynamic approaches

The terms 'psychoanalytic' and 'psychodynamic' tend to be used interchangeably. In practice 'psychodynamic' is applied to a model of briefer counselling interventions whereas 'psychoanalysis' is generally longer-term therapy. The psychoanalytic/psychodynamic model covers a range of approaches going back to the work of Freud, Jung and Adler (Tyrer & Steinberg 1999).

These approaches focus on the client's feelings, although the client may be unconscious of what causes these feelings or of what their true feelings are. The relationship between the therapist and the patient is considered an important part of the process, seen to give valuable clues about the subconscious processes going on inside the client. Psychoanalytic/psychodynamic approaches differ from cognitive and behavioural approaches in their key interest in personality and motivation (Glassman 2000).

Freud developed the idea that normal and abnormal behaviour are part of the same spectrum and believed that the study of these two phenomena could be combined. Distress, including physical symptoms, could come from reactions to traumatic events when feelings were not expressed at the time but rather suppressed into the person's unconscious. People go through various stages of development but some may experience problems at these stages and mental disturbance may involve regression to an earlier developmental stage. Within a psychodynamic approach schizophrenia is seen as:

... a severe distortion of psychological functioning, a disintegration of ego functions which results in the loss of reality testing.

(Glassman 2000)

Depression may be seen as related to earlier unmet needs, separation and loss resulting in self-hatred. Critical or punitive parenting may be another factor (Carr

2001). Anxiety in Freudian terms is linked to the struggle to keep unacceptable sexual and aggressive impulses from entering the person's conscious mind.

Within medical circles there is a certain amount of scepticism about the effectiveness of these approaches in dealing with severe mental illness. They have also been criticised for requiring lengthy and intensive periods of therapy. However, a brief intervention model (Coren 1999) has been developed and is used within university counselling services. A range of interventions are employed by practitioners. Dryden (1990) and Palmer (2000) cover three different psychodynamic approaches: Freudian, Jungian and Kleinian, in their guides to counselling and psychotherapy.

There is no one agreed set of practices in psychodynamic counselling, nor indeed an agreed set of theories, and courses bearing similar titles will offer profoundly different areas of study. Indeed, we are cautious of prescribing a specific methodology of practice as psychodynamic counsellors, preferring to argue that it is more the resultant of a reflexive and reflective attitude of mind.

(Burton & Suss 2000, 242-243)

1.5.5 Psychoanalytic/psychodynamic approaches to students' mental health

Psychoanalytic/psychodynamic perspectives are particularly concerned with emotional factors of which the student may be unaware. These include:

- consideration of the symbolic and real effects of the academic year, with its beginnings and endings (Bell 1996)
- the feelings brought up by separation from home and family (Bell 1996)
- the effects of bullying at school (Rana 2000)
- earlier conformity at school (Ryle 1969)
- the student's need to revolt against pressures that brought them to university (Ryle 1969).

The psychological vulnerability of students at Cambridge University was investigated by Surtees et al. (2000). Students' responses showed that almost 40% of students reported one or more experiences of adverse events or circumstances during their childhood or early teenage years (up to age 16). The most frequently reported event for men (16.3%), was a hospital stay of at least two weeks. For 18.9% of women this was the experience that frightened them so much that they thought about it for years afterwards. Almost 6% of women students reported being physically abused in childhood. The most commonly reported adverse effect experienced by students during

the year prior to (and following the start of) their academic course was ending a close relationship, with over 20% of students reporting the event. Other specific events frequently reported were serious problems with a friend and the death of grandparents (over 10% of students reporting such events in each year of the study).

One psychodynamic view (Rickinson & Rutherford 1998) is that at important transition points in the undergraduate learning process, students' inherent drive for maturation and academic success may conflict with their fear of losing control. This conflict can result in high levels of psychological distress as displayed by the students in their study. The authors suggest that the transition challenges are linked to the processes of: separation from parents, adjustment to new situations, and late adolescent identity formation.

Developmental approaches are drawn upon by a number of writers on student mental health. Malleon (1978) follows the ideas of Erickson, suggesting that the formation of a personal adult identity as a student is not always easy, and that the image of the student is not one that is particularly valued in the wider society. Payne (1978) reviews a number of influences on students' psychological health and their academic performance, reporting that there is a complex interplay of factors, bearing in mind:

... one thing seems certain, that both academic failure and psychological difficulty are related to the failure to master successfully the developmental tasks of adolescence, and notably the failure to achieve independence from parents and acquire a satisfactory personal identity which is not too influenced by parental attitudes and expectations.

(Payne 1978, 73)

Patterns of parenting, where there was abnormal parental attachment and a lack of appropriate levels of care and control, were found to be correlated to psychosocial disturbance in students attending a university medical centre (MacCall et al 2001).

Rutter and Smith (1995) suggest that the increasing proportion of young people involved in further and higher education may be linked to higher levels of psychosocial disorders in this age group. They offer two possible explanations. The first is that education may raise awareness of opportunities to achieve greater wealth, higher status and job satisfaction, but that there is a gap between these raised expectations and the ability to fulfil them. Secondly education has delayed the transition to adult status, meaning that young people spend longer in phases of adolescent development. The authors conclude that it is difficult to find evidence for this second point, but they do suggest that an increased period of being subject to peer pressure whilst cut off from adult influences may be a significant factor in the increase in psychosocial disorders

over time for this age group. A more recent study (Apter 2001) makes a similar point, suggesting that young adults in general may not achieve emotional independence of the parents until as late as the age of thirty.

1.5.6 Cognitive Analytical Therapy (CAT)

This approach, developed by Anthony Ryle (1982), has gained increasing acceptance in the UK (Roth & Fonagy 1996). Ryle produced a book on mental illness among students (Ryle 1969) when he was a GP in a University Health Centre, then went on to become a consultant psychotherapist. CAT is described as:

... a brief, collaborative therapy which integrates at a theoretical and practical level psychoanalytic and cognitive approaches.

(Crosseley & Gopfert 2000, 43)

From the psychoanalytic approach CAT draws on the 'object-relations' school looking at the influence of childhood and subsequent relationships with important others. From the cognitive tradition CAT draws on personal construct theory, taking the view that the individual actively constructs their own reality.

The cognitively based model which I am proposing emphasizes the way in which people actively live their lives on the basis of mental representations of themselves and the world.

(Ryle 1982, 2)

These two elements combine in the Procedural Sequence Object Relations Model (PSORM).

Intentional behaviour is part of a process which begins with an aim and may then involve an appraisal of the situation in some way, then the action itself and any evaluation after the action. CAT uses the term 'procedure' to describe this.

(Crosseley & Gopfert 2000, 45)

Psychological disturbance is seen as the result of faulty procedures:

... patterns of thoughts, feeling and behaviour linked in some recurrent sequence that end up in some emotional difficulty.

(Crosseley & Gopfert 2000, 46)

CAT is not normally offered to clients with acute psychotic symptoms or those whose lives are disrupted by drugs or alcohol, but it is used for those with anxiety problems, eating disorders, self-harm and emotional instability. The goal of CAT is to

support the client in recognising and identifying their faulty procedures and enabling them to address them through a problem-solving approach. (Palmer 2000).

1.5.7 Person-Centred approaches

Also known as Humanistic or Client-Centred, these approaches possibly differ from those above by placing much greater emphasis on the free-will of the client and their ability to make choices based on their subjective understanding of a situation. The meanings that events or action hold for clients are of interest to the therapist, perhaps in contrast to other approaches which may either see them as irrelevant or as masking the reality of the client's thought processes.

Carl Rogers is often cited as the most influential person in the development of the person-centred approach to therapy. Rogers (1951), in common with other humanistic thinkers, believed that beyond the basic biological drives humans also have a drive towards self-actualisation, the desire to grow and to develop one's capabilities. According to the humanistic theory people have both an ideal and an actual self. Where these don't match up there is incongruence and distress, for example students who set themselves impossibly high standards and so never feel they have done well enough.

Rogers saw incongruence arising from problems in the individual's development, not due to the repression of the sexual and aggressive drives as in Freudian theory, but due to lack of supportive social contact and positive relationships (Glassman 2000). Where a person has only received conditional positive regard, i.e. linked to their ability to please others, their emotional well-being is more fragile than that of someone who has experienced unconditional positive regard. In order to counter distress and disturbance, the individual needs to be helped to gain and maintain a sense of congruence between their ideal and their actual self. This involves the process of 'integration' in which:

All the sensory and visceral experiences are admissible to awareness through accurate symbolization, and organizable into one system which is internally consistent and which is, or is related to, the structure of self. Once this type of integration occurs, then the tendency towards growth can become fully operative and the individual moves in the directions normal to all organic life.

(Rogers 1951, 513-514)

Like the psychodynamic approach, the person-centred approach places more emphasis on restoring good mental functioning and emotional well-being, rather than identifying and addressing individual pathological conditions. Rogers worked with people with schizophrenia and reported that they found it helpful (Thorne 1996). The approach does not prescribe certain techniques but rather describes the conditions and quality of the relationship between therapist and client which are likely to bring about a successful outcome.

1.5.8 Person-Centred approaches to students' mental health

Ryle (1969) noted the possible effects of the lack of unconditional positive regard experienced by high academic achievers, conditional acceptance by their parents being based on academic performance. The identification of the maladaptive aspects of perfectionism, where self-esteem and the avoidance of depression are tied to a need for achievement (Rice et al. 1998), can also be linked to the concepts of conditional and unconditional positive regard.

Newsome et al. (1973) took a person-centred approach to student counselling and distinguished between academic and personal problems which adversely affected students. Academic problems included: concern over course choice, questioning 'am I good enough?' and 'how can I get enough work done?'. Personal problems included: personal identity and transition - the shock of finding that university is nothing like school, lack of preparation for making one's own decisions, over-protective or abandoning parents.

1.5.9 Systemic and Family Therapy approaches

Human systems rather than the individual are the focus of this approach.

A basic assumption of the model is that neither symptoms nor insight can be an appropriate focus for treatment interventions. Rather, the system that generates the problem behavior is the appropriate target for intervention.

(Roth and Fonagy 1996, 8)

Psychoanalytically-trained therapists were involved in the development of the family systems approach. However, it also draws on cybernetics and learning theory. Cybernetics contributes ideas of regulatory systems and feedback loops, whilst learning

theory promotes understanding of how patterns of behaviour are established and reinforced (Barker 1981).

1.5.10 Family systems approaches to students' mental health

Ryle (1969, 1972) is one of a number of writers who include a family systems approach in their analysis of student mental health problems:

... it is important to recognise that most students who consult with serious emotional or psychiatric difficulties present clear evidence of disturbance in the family background ... parental separation, divorce or quarrelling, alcoholism or psychiatric illness in the parents and distortions in the parent/child role structure of the family.

(Ryle 1972, 214-215)

This can leave the student feeling concerned about the situation they have left behind and about what may happen during their absence. More importantly the family experience is likely to influence how they think, behave and relate to others. Family pressures to succeed at university have been cited as a destabilising factor in students' mental health (Rana 2000, Ryle 1969). Ryle (1969) has also suggested that at times the university may simulate a dysfunctional family. The perception that there are increasing numbers of students with mental health problems has been linked to a general decline in family support, and to there being less stable family groups in modern society (Rana et al. 1999).

1.6 Medical approaches to mental health and illness

In the debate on the causes of mental illness the role of biology has caused much disagreement. Research has found biological differences in the brains of people with schizophrenia, depression has been linked to differences in brain chemistry and genetic research suggests patterns of inheritance (Busfield 2001, 1-2). The medicalisation of mental illness may have discouraged the explanation of 'madness' as moral weakness or demonic possession. However, there still seems to be considerably more personal stigma attached to mental conditions than to physical illnesses such as cancer or heart conditions.

Medical approaches assume a model of healthy physical and mental functioning which is seen as the result of the absence of disease or damage.

An illness suggests there is something wrong that is fundamentally different from normal function and is not just a variation in degree. The disease model regards mental malfunctions as a consequence of physical and chemical changes primarily in the brain but sometimes in other parts of the body.

(Tyrer & Steinberg 1999, 9)

A very purist biological/medical approach (Baker & Menken 2001) would say that there is no such thing as mental illness, and what we call mental illness is only the mental symptoms of physical damage or malfunctioning within the brain tissues. A more commonly accepted view (Goldberg & Huxley 1992, Carr 2000, Newton 1988) is that some people are more biologically prone to mental health problems/illnesses than others, but that life events or conditions may trigger the first appearance of, and subsequent relapses into, these conditions. This is the diathesis-stress model which underpins much of the treatment that is offered by medical services: drugs to control or reduce unpleasant symptoms, combined with advice on avoiding or coping with stress to avoid triggering further relapses. This model has been criticised by Read et al. (2004) for allowing biology any role in the explanation of schizophrenia, they see it as entirely explainable by social and psychological factors.

Psychotic disorders, anxiety, depression and other neurotic disorders have all been treated by medical intervention. Personality disorders have not been seen as treatable, leading to debate as to whether or not they are a form of mental illness (Eastman 1999). Whether people have a genetic or biological predisposition to certain mental illnesses or whether unpleasant life events bring about changes in the brain, proponents of this model will point to the effectiveness of drugs in alleviating the symptoms of depression, anxiety and psychosis. The use of Electro-Convulsive Therapy (ECT), and occasionally surgery may also be advocated by medical practitioners (Pilgrim & Rogers 1999).

Criticisms of the medical approach focus on the negative side-effects arising from many drug treatments, and the distraction of attention from the impact of important life events (Carr 2000). There have also been criticisms that mental conditions do not present the discrete clusters of symptoms found in physical medicine (Bentall 1990, Read et al. 2004). Despite this, medical approaches form the main basis for intervention with many of those who have a diagnosed mental health problem.

1.6.1 Medical approaches to students' mental health

A purely bio-medical explanation of students' particular vulnerability to mental health problems might suggest a correlation with some relevant factor such as high intelligence. Meltzer et al.'s (1995) figures showing twice the rate for functional psychosis amongst adults qualified to A-level standard and above could be taken to support this hypothesis. However the evidence for the more common mental disorders would indicate otherwise. Singleton et al. (2001) reported that people with higher IQs were less likely to experience depression. Research carried out by the Institute of Education (HEFCE 2001) using data from the National Child Development Study found that 4% of male graduates and 10% of female graduates were assessed as clinically depressed. The male graduates were half as likely to suffer depression as people with qualifications below A-level. Graduate women were no less likely to suffer from depression than people without A-levels. These findings suggest that people who go to university are not innately prone to common mental health problems over their lifetime, but that whilst they are in higher education they are more likely to experience symptoms of anxiety and depression. Comparison with figures for different age groups in the general population (Singleton et al. 2001) suggest that this is not age-related.

1.7 Integrated approaches to mental health

A number of approaches to the mental health problems of students have been examined. A recurring theme is that certain students, in common with other members of the general population, carry a vulnerability to emotional and mental health problems. Students are then exposed to the various challenges presented by higher and further education at the same time as having their existing support networks disrupted and going through a period of development and change. Whilst it has been difficult to find evidence to support a purely biological/medical explanation for raised levels of mental ill-health in student populations, social and psychological explanations suggest a number of factors which may be significant. Writers from cognitive, psychodynamic or humanistic psychological traditions may differ in their interpretations or emphasis, but they tend to agree that students face some very real challenges to their psychological and mental well being.

In the context of a profusion of psychological theories and psychotherapeutic approaches considerable efforts have been made to:

... systematically integrate differing components of psychotherapies within a coherent theoretical framework; in the United Kingdom the most notable such development is that of cognitive analytical therapy (CAT; Ryle, 1990)... This coherent and planned eclecticism is distinct from therapies in which techniques are 'borrowed' in the absence of a guiding framework.

(Roth & Fonagy 1996, p4)

Rather than arguing that there can be an integration of approaches under one psychotherapeutic umbrella, as in the case of Cognitive Analytic Theory, Tyrer and Steinberg (1999) suggest that distinct social, psychological and medical approaches can address different levels or stages of mental disorder. The authors offer their own 'integrative model' which allows social, psychodynamic, cognitive, behavioural and biological models to be applied at different stages in the person's experience. The central tenets of Tyrer and Steinberg's integrative model are that:

We each have several levels of functioning ranging from biological functions through to personal decision making

When mental disorder develops it can affect one or more levels

At different times in the course of the disorder the predominant level of dysfunction may change

Each model in psychiatry links specifically to one level of function

Successful treatment of mental disorders involves matching the main level of disturbance with the appropriate model and its philosophy of management.

(Tyrer & Steinberg 1999, 113)

A practical implication of this integrated model is that the level of distress determines treatment. If a person has mild mental distress, due to identifiable external causes, it would not be appropriate to intervene beyond the social or psychodynamic levels. If, on the other hand, the person is clearly severely ill, out of touch with reality, experiencing personality disintegration etc, a disease-level intervention will be required before any other level of intervention can be effective.

Whilst this model fits broadly with the way that mental health problems are dealt with in our society it would not find universal acceptance. Biological/medical interventions continue to attract criticism (Johnstone 2001, Read et al. 2004). Some cognitive-behavioural practitioners may not agree that a psychodynamic approach is necessary at all, at either a mild or a moderate level of distress (Ellis 1988). They would dispute that cognitive approaches do not address feelings. In turn medical practitioners may be suspicious of the effectiveness or even hazards of using psychotherapeutic approaches for serious mental illnesses (Baker & Menken 2001).

Goldberg and Huxley's (1992) bio-social model represents an integrated approach suggesting that mental health is affected by vulnerability, destabilisation and restitution. 'Destabilisation' describes a phase in which vulnerable individuals experience life events which provoke the onset of illness and the experience of symptoms. Particular events may lead to depression, anxiety or a combination of the two. 'Restitution' refers to the loss of symptoms. According to the authors, restitution may be aided by: social support, life changes, social work interventions, interventions by nurses (including behavioural psychotherapy), psychotherapy by GP referral, specialist treatment and drug treatment. They do not advocate the use of psychodynamic therapy but do call for an approach to treatment which combines social, psychological and medical perspectives. The authors express concerns about the abilities of social workers, nurses, clinical psychologists and psychiatrists to work across these three perspectives, but that is exactly what is now expected in the UK's multi-disciplinary Community Mental Health Teams.

A multi-disciplinary approach recognises that it is not possible or perhaps even desirable to be an expert in all the five approaches set out in Tyrer and Steinberg's (1999) model of mental disorder. This model acknowledges the need to consider the environment in which people live and work, but its main focus is professional activity rather than the operation of less formalised networks of support. It is a model of an integrated approach to psychiatry rather than a wider model of mental health in a community.

The World Health Organisation (WHO 2000) model of functioning and disability provides a framework for integrating support between health services and the wider community. It distinguishes between impairments which are the restrictions in functioning experienced by individuals, limitation of activity resulting from the impairment, the lack of participation in society resulting from limited activity, and lack of participation caused by external barriers and hindrances. The model fits with a social model of disability (Barnes & Shardlow 1996, Beresford 2002, Oliver 1990), suggesting that mental health problems can be tackled at different levels: the source of the problem, the impact on functioning, participation in social activities, and reduction of barriers in the person's social environment.

The distinction between these individual and social aspects of disability and functioning is a main feature of the psychiatric rehabilitation model (Anthony et al. 1988). This identifies three components required to support sustained recovery from

severe mental health problems. Firstly, the underlying condition or ‘pathology’ must be treated. Secondly, the individual must be given skills training and individual support to improve their functioning. Finally, the environments in which they are to live, study or work must be developed to become more enabling. This approach was first developed in the USA, which preceded this country in adopting an anti-discrimination approach to mental illness and other disabling conditions.

The recovery model (Deegan 1998) is closely allied to the psychiatric rehabilitation model and also attempts to transcend the differences between individual and social aspects of mental health. This model emphasises the possibility of recovery from mental health problems through the individual’s active engagement in their own rehabilitation. Services can promote recovery by recognising the individual’s civil rights, by expressing the belief that recovery is possible and by facilitating engagement with education, work and leisure activities (Anthony 2000). Recent UK legislation on disability rights for students (DRC 2002) may reinforce the need to look beyond individual pathology in this way to the wider picture of institutional policies, procedures and mechanisms for support involving both healthcare and educational institutions (RCP 2003).

1.8 Support for students with mental health problems

The provision of specialist support for students with emotional and mental health problems goes back to the 1950s when medical practitioners started to realise that there was a psychiatric or psychological component to certain students’ academic difficulties. In subsequent years the expansion of the old universities and the creation of new ones reduced the pastoral support available from tutors, whilst psychiatric support was seen as stigmatising and associated with illness. This left a gap which was filled by the creation of university counselling services (Payne 1978).

Many educational institutions have recognised that they can be active in promoting the mental health of their students and responding to the needs of those who have mental health problems. However, some writers (Bristow 1996, Furedi 2004, Wessley & Hotoph 2001) have criticised the idea that institutions should be concerned about the psychological health of student populations, seeing it as pathologising issues which students ought to be able to deal with. Despite these theoretical objections, many educational institutions have found that there are practical reasons for putting

support mechanisms in place, including avoiding liability for misadventure and improving student retention (AMOSSHE 2001).

Education in itself can be seen as a positive influence on mental health. Whilst acknowledging that universities do not set out to be therapeutic institutions, Rana (2000) points out that the atmosphere is:

... one that encourages thinking and the cultivation of understanding and, as such it is conducive to psychological growth and development. For some students... whose previous life experiences have failed to equip them adequately for adulthood, university may provide a second chance to develop some of the tools they may need later in life.

(Rana 2000, 158)

The guidelines produced by the Committee of Vice-Chancellors and Principals (CVCP 2000) acknowledges the importance of education for mental health.

... there is a challenge to institutions to help students to capitalise on the positive mental health benefits of higher education, whilst identifying, and providing support to, those who are more vulnerable to its stresses.

(CVCP 2000, 10)

Policies have to be developed on how to provide for the needs of students with a disabling mental health condition without compromising academic standards (Earle & Sharp 2000). In their guidelines (CVCP 2000) the CVCP, now Universities UK, suggested areas which should be covered by institutional policies and procedures, and proposed that institutions should provide clear routes of access to internal support services, with encouragement of co-ordination between relevant support services. They also emphasised the importance of partnerships with external agencies, a point also made in the Royal College of Psychiatrists' report (RCP 2003).

1.8.1 The framework for student support in academic institution

Different sources of student support will vary between institutions in the extent to which they are deliberately co-ordinated, have evolved ways of working together, or perhaps appear haphazard. The policies and approaches which are adopted by academic institutions in relation to student support and mental health may reflect how (if at all) the problems are conceptualised. Earwaker (1992) argues that students' problems must be seen as a combination of both social and psychological factors, with the consequence that the academic institution must not focus solely on changing the student but should also look at how it can change itself. The problem here is that institutional change can

be a slow process, whereas the students have a limited time in which to sort out their problems, if they are not to fall seriously behind with their work.

Over time institutions have changed the way that they address students' needs. One example is the separation of counselling services from university medical centres (Bell 1996), with self-referral rather than GP referral for counselling. This separation may mark the recognition of counselling as part of a range of services which support the students in their learning rather than as a purely therapeutic process (Milner 1974, Noonan 1978, Rickinson and Turner 2002).

Bell (1996) points to the danger of the rest of the institution seeing the counselling service as either the ideal solution to the organisation's problems, or as a repository for problem students, enabling the institution to distance itself from the problem areas. This latter view may lead to the situation where some individuals may:

... denigrate the service as useless and inappropriate; they do not value it, because for them it represents the needy aspects of themselves or the organization which they in some ways also despise and would like to be rid of.

(Bell 1996: 49)

To counter these dangers, Bell suggests that an active involvement in the wider institution can be healthy for both counselling services and universities and can raise the profile of the service amongst students. An understanding of students' support preferences will help institutions target their support effectively.

Rickinson and Turner (2002) suggested a model of support provision based on their experience at the University of Birmingham where students have personal tutors who are charged with the responsibility of supporting the student and liaising with other support agencies. Both the student and tutor can get advice and support from a student support and counselling service which has staff specialising in: specialist learning support, welfare, disability, mental health needs, international students and counselling. In addition the university is served by an NHS medical centre and hires the services of a consultant psychiatrist.

1.8.2 Pastoral responsibility and duty of care

At the older universities in particular, systems of pastoral care go back to the time when students under the age of twenty-one did not have full legal adult status.

This form of support is often linked to a collegiate system and a personal tutor. The newer universities tend to have less devolved systems with more centralised student support (Earwaker 1992). In recent years rising student numbers, combined with additional pressures on staff, have resulted in less tutor contact for students in many universities (Rana et al. 1999). Further Education Colleges similarly are facing financial pressures and heavy workloads for staff, which may weaken the tutorial relationship (Gibbons 1998).

From a public health perspective, Stewart-Brown (2000) has suggested that concern for the well-being of students should extend to considering the impact of current stress on their lives after college or university. Prolonged stress can affect the immune and cardiovascular systems (Martin 1998), resulting in poorer physical as well as mental health. Stewart-Brown warns that, if high levels of emotional distress are regarded as normal, students may tend to seek high-stress occupations and establish a life-long pattern of stress and anxiety. However, two recent studies (Singleton 2001, HEFCE 2001) have concluded that graduates enjoy better mental health than non-graduates. So, in the long term, it may be that most students deal with the stresses from their time at university or college. However, this does not mean that the high levels of stress experienced at the time should be accepted as normal, especially as they may act as a trigger for students who are vulnerable to mental health problems.

Recent guidance from professional bodies (AMOS SHE 2001, CVCP 2000, RCP 2003) advises that higher educational institutions have a duty of care to their students and that policies and procedures on student mental health should be in place. However, the division of responsibilities between academic and healthcare support systems can be problematic. The Heads of University Counselling Services (Rana et al. 1999) expressed concern that university counselling services were increasingly dealing with students with severe psychological disturbance for whom it was hard to find the appropriate level of intervention. Their report identified problems related to communication and the clarification of professional boundaries between university counselling and local health services.

1.8.3 Impact on academic achievement and student retention

A pragmatic reason for academic institutions' involvement with the mental health of their students is that those who are stressed, anxious, depressed or suffering from severe mental health problems are in danger of dropping out, underachieving, or

failing on their assessed work. This is not only a personal tragedy for the student concerned but represents a loss of income for their institution and a poor return on the public investment.

Students with poorer mental health are more likely to have considered dropping out of university (Roberts 1998). One study (Szulecka et al. 1987) found that students with General Health Questionnaire (GHQ) scores greater than 6 were more likely to withdraw than those with lower scores. Forty eight students who withdrew voluntarily had higher GHQ scores than another fifteen who withdrew through academic failure. Withdrawal from university was found to be correlated with unsatisfactory relationships with parents and with experience of previous psychological investigation or help. The figures on student withdrawal suggest that emotional factors are more significant than academic pressures or intellectual difficulties. However, students with high scores for anxiety and depression who receive counselling are more likely to complete their course successfully than those who do not receive support (Rickinson & Rutherford 1995, Rickinson 1997).

The research into the impact of mental health and well-being on academic achievement has produced some contradictory findings. Nearly 18% of students in a study at Nottingham (Wolfson 2001) reported that they were unable to work as well as they used to and experienced higher levels of anxiety and depression. In contrast Halamandaris (1995) found no correlation between academic performance and students' psychosocial adjustment and satisfaction with university life. Another Scottish study (Monk 1996) of a small sample (45) of students found that stress levels had little impact on their academic results. However, strong associations were found between social and psychological factors and academic outcome in a sample of 834 students at Cambridge (Surtees et al. 2000).

Psychological problems may not only result in poorer academic performance. Up to a certain level, anxiety and perfectionism may drive up students' performance (Ryle 1969, Rice et al. 1998). A now rather dated study (Kelvin 1965) reported a higher incidence of neurotic disorders amongst students who gained Firsts, greater than those who failed or dropped out, with the lowest incidence amongst students with other classes of degree. More recently Surtees et al. (2000) found that female Cambridge students with an increased score for neurotic symptoms were up to four times more likely to achieve a first class mark than those with relatively low neurotic scores. However, amongst the male students, those with a high neurotic score were half as

likely to gain a first class mark as those with a low score for neuroses.

1.8.4 Student suicides

Following concern over an apparent rise in recorded national figures for annual student suicides from 80 cases in 1990 to 140 in 1998 (Gusmaroli 2000), Universities UK commissioned research to establish more accurate figures on the levels of suicide in university student populations. The resulting report (UUK 2003) concluded that it was difficult to obtain robust data, but on the basis of the information available students were at least as likely to commit suicide as members of the general population. Whilst the incidence of student suicide and attempted suicide is less than that of many other mental health problems, the ever-present possibility of suicide within student populations has strengthened the case for providing university-based support systems (Tysome 1995, Hawton et al. 1995b, Stanley & Manthorpe 2002).

There was particular disquiet and adverse media coverage regarding student suicides at Oxford University in the 1990s when ten suicides occurred within four years (Ellis 1993, Bell 1996), and more recently in Edinburgh where there were six student suicides in six months (Bowditch 2000, Templeton 2001). Whilst we have seen that the actual suicide rate for Oxford University students is not significantly higher than for the local population (Hawton et al. 1995b), the fact that young people with such demonstrable potential should resort to suicide has led to accusations (Sengupta & Ward 1997, Akkerhuys 2000) that it is the pressure at university that is to blame. In order to lessen the risk of student suicide Hawton et al. recommended:

[There should be] careful induction of students when entering university in order that all are aware of the demands they are likely to face and know where to obtain support and help if they need it.

[Means of] alleviating the stress of academic work should be sought.

[Counselling services for students] must be attractive, easily accessible, and sufficiently well-staffed to provide prompt help for as many students as require it. Psychiatric services must also be easily accessible and have close links with the counselling service.

(Hawton et al. 1995b, 50)

1.8.5 Provision for disabled students

Educational institutions have a responsibility to put support in place and make adjustments to accommodate the needs of disabled students, including those with recognised mental health conditions (DRC 2002, QAA 1999). Many Universities have

now accordingly appointed disability advisors who work at an institutional level to improve policies, procedures and facilities, and at an individual level with disabled students to ensure that they get the aids, adaptations and adjustment they require to function academically. Some have gone a step further and appointed specialist mental health advisers or support workers (Stanley & Manthorpe 2002).

1.9 Help-seeking behaviour amongst students

The research literature shows that students have preferences as to where (if at all) they seek support. Their help-seeking behaviour is likely to be influenced by what they are seeking support for, what support is available, how they view their problems and their perceptions of the support available. Information on students' help-seeking behaviours will indicate where future support needs to be targeted and whether it is necessary to raise students' awareness of other sources of support.

1.9.1 How many students seek help?

In an Oxford College 63% of the students felt that there was a stigma attached to seeking help from a professional (Sell and Robson 1998). A survey of Cambridge students (Surtees et al. 2000) found that only 10% reported seeking help for mental or emotional problems from a service. In the same study 35% of the students reported one or more defined problems, but did not seek help, and around 10% of students reported emotional problems for which they (or others around them) thought professional help should be sought but for which they did not request help. Similarly at Birmingham University (Rickinson 1997) 30.5% of a sample of students with a high level of psychological distress did not seek help from the counselling services. In Dublin (Moukadem 1995) 41% of a sample of 91 students had scores on the GHQ that indicated clinical psychological problems, but none had used the University counselling service.

Tutors at Hull University (Stanley & Manthorpe 2000) reported that a significant proportion of students with problems did not seek counselling or other professional help because of the perceived stigma. The most common obstacle encountered was 'the student's own inability to recognise the problem or be prepared or accessible to receive help.' (Manthorpe & Stanley 1999a). Staff on nursing or social work courses had particular concerns about the impact of disclosure of students' mental health problems

on those students' future career prospects.

Hawton et al. (1995a) studied the records of Oxford University students who attempted suicide over a 15 year period. Of these students:

- at least one in five had seen their GP in the preceding month
- 15% had seen a psychiatrist
- Three were psychiatric inpatients at the time of their attempts
- Only 5% were known to have contacted Nightline (University telephone support line)
- Only 2% were known to have contacted the Samaritans
- 35% of students were known to have been in contact with some potential helping agency in the month before their attempt.

Hawton et al. states that these figures are likely to be underestimates, but they indicate that a substantial proportion of attempters did not contact any formal sources of support.

Reluctance to seek help for mental health problems may reflect the associated stigma in society generally, or within particular sub-cultures (Pilgrim & Rogers 1999, Mind 2000). It could also result from a certain fatalism or lack of awareness that anything could be done. This may be something which changes according to age and experience (Oliver et al. 1999).

1.9.2 Where do students seek help?

The research literature indicates that students may be particularly reluctant to take their emotional or mental health problems to a GP. A study at Oxford Brookes University (Wyville-Staples 1998) found that whilst 49% of student respondents had used services at a medical centre, only 4.6% of the student sample had consulted a GP for mental or emotional problems. At Cambridge (Surtees 2000) only 6% of students surveyed had consulted a GP about their mental health. Within this figure it should be noted that twice as many female students as male students approached their GPs. In a study of students at an Oxford college (Sell and Robson 1998) most said that they would turn first to a friend for help, after that in descending order: a family member, the college doctor, university counselling and Nightline and lastly the moral tutor within the

college. In Dublin only 4% of students indicated they would take mental or emotional problems to a GP (Tyrrell 1993).

The research reviewed indicates a range of 4%-10% of students using counselling services (Grant 2002, Surtees 2000, Wyville-Staples 1998). There is evidence that students will make a distinction between support for stress and for major mental health problems (Wolfson 2001, Ciarrochi & Deane 2001, Oliver et al. 1999). Students suffering anxiety linked to 'homesickness' are more likely to confide in others, but students with more serious depression and anxiety may avoid contact with other people (Brewin et al. 1989). In the study of an Oxford College (Sell & Robson 1998) students' families were cited as the first choice for emotional support. In Leicester (Grant 2002) 65% of students named families as a source of support, and the same percentage cited friends. At Trinity College Dublin (Tyrrell 1993) 78% of students said they used friends for emotional support.

Studies in Leicester (Grant 2000) and Nottingham (Wolfson 2001) showed 54% and 47% of students respectively indicating tutors as sources of support, and this is borne out by research involving academic staff (Grant 2000, Easton and Van Laar 1995, Manthorpe and Stanley 1999a). Other sources of support accessed by students include:

- Hall wardens (Wolfson 2001, Wyville-Staples 1998)
- Student Union officers - 10% of students (Wyville-Staples 1998)
- Chaplains or similar faith-based staff - 1.5%-3% of students (Wyville-Staples 1998, Grant 2000, Tyrrell 1993, Sell and Robson 1998)
- Nightline was used by a few students (Sell and Robson 1998).

1.9.3 Professional recognition of mental health problems

The number of people with mental health problems who present themselves to medical practitioners, and are then recognised as having a mental illness, does not represent the number who have potential mental health problems as measured by surveying a population. According to Goldberg and Huxley's (1992) research, in one year between 260 and 315 people out of 1,000 in the general population will experience an episode of 'mental disorder' lasting at least two weeks. Of these 230 will present themselves to a GP, but often presenting with physical rather than mental symptoms.

Only 101.5 will have their mental disorder recognised by the GP. The authors offer a model of a series of filters from the community to psychiatric care. The first filter is that of illness behaviour – presenting oneself to a doctor. The second filter is the doctor's ability to detect mental disorder in patients. The third filter is the doctor's decision to refer the patient on to mental illness services. The fourth and final filter is the decision whether to admit the person for psychiatric in-patient treatment. Those with the psychotic disorders are much more likely to pass through the four filters than those with other conditions.

The gap between the possible 315 out of 1,000 people who may be identified as having a mental disorder by completion of a General Health Questionnaire, and the 101.5 who have their disorder recognised by a GP can be looked at in two ways. On the one hand this is a serious situation where many people are suffering in the community and would benefit from medical intervention in their lives. Alternatively there could be relief that not all of human suffering is medicalised and that people may use a range of options to help themselves of which the GP is just one. The truth probably lies somewhere in-between.

Meltzer et al. (2000) using a different instrument (the Clinical Interview Schedule CIS-R), has found that those with the most severe neurotic symptoms are the least likely to seek help from a GP. The two most common reasons for not seeking help were 'Did not think anyone could help' and 'A problem one should be able to cope with'. Meanwhile a GP points out that there are items on the GHQ with which a person could identify due to life events, and these are not necessarily the same as having depression.

General practitioners should not be castigated when they try, alongside the patient, to find out what is the matter rather than to make a diagnosis

(Heath, 1999, 440)

When MacCall et al. (2001) sampled 434 students attending a Scottish university health centre, 65% of the female and 54% of the male students had GHQ scores indicating 'psychiatric caseness'. However examination of the centre's medical records showed that 'psychological morbidity' was recorded as present in only 14% of consultations. Whether this disparity was due to students not presenting their mental health problems, doctors not recognising the problems, or a GP's reluctance to record a mental health condition on the student-patient's notes is not clear.

1.10 Sources of support

In recent years there has been apprehension that students are not getting the support they need for their psychological problems and that this is having a detrimental effect on themselves, fellow students, academic staff and counsellors. The role of organisations, agencies and individuals who support or treat students with emotional or mental health problems has been raised by the Heads of University Counselling Services report '*Degrees of Disturbance*' (Rana et al. 1999) which highlights the fact that university counsellors are dealing with increased numbers of more psychologically disturbed students whose needs would be better met by the health services. This situation has implications for the responsibilities of tutors, counsellors, GPs and mental health care staff. It also provokes questions about professional boundaries and the resources available to provide mental health services to student populations (Lago 2002).

1.10.1 *Support from friends, family and peers*

This review has already established that students are found to be more likely to talk to friends or family than a professional about their emotional concerns. The availability of social support is a significant factor associated with mental well-being (Argyle 1990, Newland & Furnham 1999). However, whilst students may feel content to know that support is potentially available, they may not be so happy that they have needed to access it. A survey of US graduate students approaching their law bar exam (a highly stressful event) found that:

Although the perception that support is available is associated with better adjustment the perception that one has been the recipient of supportive acts is not.

(Bolger N et al. 2000)

This bears out other research (Newland & Furnham 1999) on the effectiveness of perceived rather than enacted social support on reducing feelings of homesickness amongst first year university students.

Families appear to be both sources of support and stress to students. One factor in going to university can be the need to get away from family pressures (Halamandaris 1995). Students can find difficulties in maintaining their loyalties to families at home and their friends at university (Grayson et al. 1995). Mature students with families of their own can find it particularly hard to balance time to study with family

responsibilities and often paid work too:

When asked how he managed multiple roles, one male student said 'it completely alters the world around you. Returning changes everything about your life. Its not just the degree of difficulty with the work, it's just finding the time to do it all. It was the first time I've understood how someone could crack up.'

(Leger 1996: 129)

However, families come high on students' lists of personal supporters. In Dublin (Tyrrell 1993) 94% of students sought the support of a close friend, 82% sought support from parents and 72% from siblings.

Whether a close confidante is a family member or friend, the absence of a close confiding relationship has been found to be the most significant factor in predicting depression and anxiety (Harrison et al. 1999). Surtees' (2000) study of Cambridge students found that over a third of the respondents reported the availability of a close confidant in each year, with nearly half of the respondents reporting a confidante in 1997. Around 40% more women than men reported the availability of a close confiding relationship. 70% more postgraduate than undergraduate students reported availability of a confidante. If the findings of a study of Australian undergraduates (Ciarrochi & Deane 2001) have relevance to the UK, it is likely that those students who can seek help for emotional problems from friends and others are also more likely to seek professional help for more severe problems such as having suicidal feelings. Conversely those with poorer 'emotional competence' are less likely to seek help from either source.

Students who find themselves supporting fellow students with mental health problems can become weighed down by the responsibility and may end up contacting student counselling or advice services for assistance themselves (Lago 2002). Formal peer support training (Bell 1996) can go some way towards helping students within a college or similar community to lend a listening ear, whilst setting realistic boundaries to their support and offering information of other sources of help. Another form of peer-support is student 'Nightline' services. Students operating such voluntary Helplines can find taking calls stressful and demanding, but are supported by the presence of other volunteers with whom they can 'debrief' (Pereira & Williams 2001). Literature searches have not revealed any evaluations of these types of generalised peer support mechanisms in the UK. A study of a one-to-one graduate student peer mentoring scheme in the USA (Grant-Vallone & Ensher 2000) concluded that such support, whilst not reducing students' perception of being stressed, did result in higher levels of reported psychosocial support.

1.10.2 The role of academic staff in supporting students

This review has already indicated that academic staff come high on the list of student preferences for sources of support, following family and friends. Fifty two percent of a sample of staff at Leicester University reported interactions with students with mental health problems (Grant 2000). At one of the older northern UK universities (Stanley & Manthorpe 2001) 35% of staff reported supervising students with mental health problems. Sixty percent of cases appeared to involve mild problems, but 28% were described as 'serious or life-threatening'.

In a survey at a former polytechnic (Easton and Van Laar 1995) 97% of lecturers responding reported having 'counselled' one or more students during the previous year who were distressed as a result of problems including: bereavement (44%), depression (42%) and relationships (37%). Although 76% of the respondents considered helping distressed students to be part of their role, only 22% felt that they knew enough about helping distressed students. Similarly in a survey of lecturers in a college of further education (Hart 1996) tutors felt unprepared and unsupported in their counselling role. They used a smaller range of skills than counsellors and tended more towards advice-giving and directive techniques.

In another study of university academic staff, 53% had been a supervisor or advisor of students with mental health problems in the previous academic year when these 71 staff members had supported 102 students with mental health problems, and 20% of the problems were rated as severe (Wassall 1999). The staff were more likely to contact academic colleagues or the student's GPs, rather than the university counselling service. Difficulties for staff in helping these students centred around lack of time, not feeling skilled or knowledgeable in this area, not being aware of an official policy to fall back on. Staff identified being able to recognise a mental health problem and knowledge of appropriate referral systems as a training need.

Whilst staff teaching professional training programmes, such as nursing and social work, are probably more aware of mental health issues, they face a dilemma. Students on these courses have to prove their competence and safety in working with vulnerable client groups. Disclosure or diagnosis of certain mental health problems may have an impact on their career choices to an even greater extent than for students on other technical or non-vocational courses. Staff have to tread a careful path in

raising mental health concerns with such students (Manthorpe & Stanley 1999a).

In addition to the issues of training and support for staff there is apprehension about stress levels among academic staff themselves (Kinman & Jones 2000, Gibbons 1998, Fisher 1994). In a small study involving university students (Grayson et al. 1998a) the majority saw lecturers as a potential source of help for personal as well as academic problems, the key factor in this decision being not the professional competence of the lecturer, but rather the student's perception of the lecturer's personal involvement with them. The authors comment that in the context of increasing student numbers and other demands on staff such as research, writing and quality assurance inspections, students may not see lecturers as being so approachable in the future.

The supportive role of academic staff goes beyond one-to-one support and referral to other sources of help. Practical suggestions for reducing academic stress from students in a University of Oxford College (Sell & Robson 1998) included appeals for tutors to be more supportive, alert to signs of stress in their students and more skilful in their teaching methods. A small-scale study of students with mental health problems entering further/community education classes (Leach et al. 1997) found that lecturers had a crucial role to play in making the students feel safe and welcome in their classes. The requirements of UK anti-discrimination legislation confronts lecturers and tutors with the need to make reasonable adjustments for students with long term mental health problems (DRC 2002). At present most guidelines available to staff (e.g. Open University 1994, CVCP 2000, Ferguson 2002) focus on identifying and accessing support for mental health problems. In the future the focus is likely to expand to include good practice in teaching students with mental health problems. The Higher Education Council for England (HEFCE 2002) invited bids to develop inclusive teaching strategies for disabled students over a three year period from 2003.

The supportive roles of non-teaching staff working within higher and further education e.g. librarians, hall wardens, administrative staff, porters, cleaners etc has not been discussed in any detail in the literature. However, their involvement has been acknowledged (Stanley & Manthorpe 2002) especially in relation to identifying students at risk of suicide.

1.10.3 Advisory services for students

Some universities and colleges (Rickinson & Turner 2002) have appointed

specialist advisers for particular groups of students, e.g. international students, mature students and disabled students. Students' unions often have an advice and welfare section offering help with a range of student concerns. Educational institutions provide careers advice services and some offer support with study skills and examination techniques. The extent to which these are used by students with mental health problems is not clear from the literature, but the value in providing such services is mentioned by a number of authors.

International students face all the stresses encountered by home students plus the additional pressures of adapting to a new culture and being at a great distance from family and friends. Javed (1989) identifies the need to help students integrate into the host culture through the provision of specialist support. Academic, counselling and advisory staff could benefit from training in the impact of cultural differences on their work (Bradley 2000).

Earwaker (1992) makes the case for student support services to be seen as integral to the higher education experience, and not merely as a back-up service. He argues that change and development is all part of the higher education process and needs the appropriate level of support. Support services themselves need to link-up different functions e.g. counselling services being able to refer students to advice services for help with finance or accommodation and vice-versa when problems cannot be resolved by advice alone (Bell 1996).

1.10.4 Counselling services

... the focus of Counselling is more likely to be on specific problems or changes in life adjustment. Psychotherapy is more concerned with the restructuring of the personality or self. (Standing Conference of Educators and Trainers in Counselling and Psychotherapy 1977)

Psychologically-based therapeutic interventions are termed as either 'counselling' or 'psychotherapy'. Distinguishing between the two is not simply a matter of approach, as there are both counsellors and psychotherapists using psychodynamic or cognitive approaches. According to Dryden (1990) counselling and psychotherapy share the same core activity, but the former is concerned with human development and growth informed by educational and spiritual models, whereas the latter is employed in the treatment of mental disturbance or illness and is more influenced by a medical perspective. Feltham (2000) not only distinguishes between counselling and psychotherapy, but also between counselling and the use of counselling

skills by non-counsellors.

Counselling skills involve active listening, keeping the focus on the other person, maintaining some boundaries of confidentiality, working towards a goal and is thus distinguished from normal conversation. Counselling is more formalised, involving:

... an explicit agreement between a counsellor and client to meet in a certain, private setting, at agreed times and under disciplined conditions of confidentiality, with ethical parameters, protected time and specified aims.

(Feltham 2000, 4-5)

Of course the same is true of psychotherapy. Feltham, like Dryden, sees counselling focusing on a range of life problems including loss, relationship difficulties, anxiety and depression, whilst psychotherapy addresses deeper levels of personality problems and disturbance. Psychotherapists are likely to have undergone a more lengthy period of training than counsellors, and to see clients for a longer and perhaps more intensive period of time. However, Feltham admits that it is not always easy or possible to distinguish between counselling and psychotherapy.

More has been written about student counselling than any other intervention connected with students' mental and emotional well-being. In the last thirty years at least seven books have been published on the subject (Bell 1996, Lago 1994, Lees & Vaspe 1999, Milner 1980, Newsome et al. 1973, Noonan 1978, Rana 2000) as well as many journal articles. A key question for these authors is that of determining the appropriate client group for student counselling services. Early on Newsome et al. (1973) identified the need for clarity about the purpose of counselling:

... counsellors need to be clear that their main area of concern will be with people who are experiencing normal developmental difficulties together with only a small number who are undergoing moderate or even severe personality problems. They are bound, too, to be confronted at times by the more severe clinical disorders, but usually such cases will be beyond their competence and their main task will be to recognise this and to make the appropriate referral.

(Newsome et al. 1973: 10)

The Association for University and College Counselling has produced a list of 'client concerns' (AUCC undated), notified to them by members and used to collect data for an annual survey conducted by the Association. This list covers a wide range of presenting problems, from mild worries about academic work to severe psychotic breakdown. There is evidence that counselling services encounter many severely distressed students. Seventy-nine percent of a sample of students using a university

counselling service (Rickinson 1997) were assessed as having 'potential psychiatric illness' using the Global Severity Index (GSI). At the same time, a control group of students matched for age and study profile but not using counselling services were tested and 30.5% had scores indicating potential psychiatric illness. In a study of Cambridge students using the university counselling service (Surtees 1998), counsellors recorded dominant symptoms of depression in 62% of cases, and anxiety in 53%. Disquiet about the increase in seriously psychologically disturbed students using counselling services has already been mentioned (Rana et al. 1999) and this will be looked at in the next section of the review, in the context of the relationship between student counselling services and healthcare providers.

Newsome et al. (1973) stated their belief that psychoanalytic approaches are beyond the scope of an academic counselling service, viewing them as too deep and long-term for use by a service which is essentially supporting young people to become successful students. Instead they favoured a person-centred approach which they saw as more focused. By contrast, more recent writers (Bell 1996, Coren 1996 & 1999, Rana 2000, Rickinson 1999) advocate a psychodynamic approach as being quite suitable when used in a brief therapy form. Cognitive behavioural approaches are used, but are less in evidence (Rattigan 1989, Bell 1996, Rickinson 1999). In practice many counsellors may employ an 'eclectic' or 'integrated' approach within their brief work with students (Rattigan 1989), but the basis on which they choose to do this is not made clear. Tyrer and Steinberg's (1999) model suggests that cognitive, behavioural and psychodynamic approaches should each be applied to different levels of mental disorder, but the different approaches used are more likely to reflect the preferences of those running counselling services.

In analysing the effectiveness of a student counselling service a survey of 246 users at the University of Cambridge (Surtees 1998) reported that one year after receiving counselling:

- 23.5% had no episode of mental ill-health
- 25% had shown an improvement
- 50% had recurrent episodes of mental health problems.

Users of the Cambridge University counselling service were more likely to withdraw from their studies than non-users (Surtees et al. 2000). In another study at Cambridge Collins and Paykel (2000) concluded that it was not possible to determine

the impact of the counselling service on preventing suicide.

At the University of Birmingham, final year students who had received counselling during their studies showed a statistically significant improvement in the Global Severity Index scores, whereas members of a matched control group did not (Rickinson B 1997). Counselling targeted at first year students considered to be at risk of withdrawing was found to be effective in improving retention rates (Rickinson & Rutherford 1995). However, these studies are based on relatively small samples and we shall have to wait for the results of the Clinical Outcomes in Routine Evaluation – Outcome Measure project (Evans 2002) which covers a number of universities with a large student sample to find more generalisable results. Counselling staffs' ambivalence regarding formal evaluation (Parker 1999, Smith 2000) can conflict with the growing trend for evidence-based practice in counselling and psychotherapy (Mellor-Clark 2000).

1.10.5 Primary care

A recent chapter by a GP (Jacobson 2002) entitled 'Identifying Students' Mental Health Needs in Primary Settings' focuses on the treatment of adolescents and young adults, saying very little about the way that student populations are treated. Research indicating that student populations experience much higher levels of psychological distress than might be expected for their typical age group (Stewart-Brown et al. 2000, Webb et al. 1996), suggests the need for more research into students' use of primary care services.

Issues of professional boundaries and confidentiality affect the GP's relationships with other student supporters (Bell 1996). Ryle (1969) saw the GP's role as supporting both the student and, if necessary, their tutor so that they could concentrate on the academic side of their relationship. However, academic staff have reported frustration in their attempts to obtain collaboration with GPs (Stanley and Manthorpe 2001). Primary care provides the gateway into mental health services and GPs have to decide what distinguishes psychosocial problems from mental illnesses (Jacobson 2002). MacCall et al.'s (2001) finding that GPs are either not identifying a significant proportion of students with psychological problems, or are reluctant to record such problems on the patient's notes, indicates one difficulty in identifying the numbers affected.

Within primary care there has been interest in comparing the effectiveness of anti-depressants with that of counselling for the treatment of mild to moderate depression. Chilvers et al. (2001) have concluded that, at this level, 'generic counselling' is as effective as antidepressant drugs and found that, given a choice, more patients opted for counselling. Ward et al. (2000) found that non-directive counselling and CBT were both more effective than 'usual general practitioner care' for patients with depression after four months, but that after 12 months there was no difference between them. Wagner & Simon (2001) urge caution over Chilvers' results, both because they used generic counselling rather than specified interventions such as CBT, and because a large proportion of the sample refused randomisation of treatment, with many of them opting for counselling. These findings and others of a similar nature present a dilemma to the providers of primary care. They must be responsive to patients' wishes which tend to favour counselling over medication. However, if there is no conclusive proof (provided by the 'gold standard' test of the randomised control trial) that in the long term counselling or CBT are more effective than drugs, then the latter, as a cheaper and more readily available option, must seem attractive.

1.10.6 Secondary care

Very little has been written on the role of the psychiatric sector in relation to students since some initial interest in the 1950s and 60s (Davidson et al. 1955 & 1964, Ryle 1969). Forty or so years on there have been many changes in the student population, in the academic world and in the provision of psychiatric services (Wessley 1996). Manthorpe and Stanley (2000) identified academic staff's need for a better understanding of psychiatric services and for clearer pathways of communication, but did not provide an evaluation of the effectiveness of such services in supporting students with mental health problems. Typically much of the commentary on secondary mental health services comes from writers on student counselling. Identified difficulties in working with the psychiatric sector include:

... the under-provision of psychiatric and psychotherapeutic services within the NHS.
[available services] are not always being appropriate to the student population.
... students may not be resident in the hospital catchment area for significant parts of the year.
(Bell 1996, 136-137)

Within the medical system another related debate concerns the division between primary and secondary care over the treatment of depression and anxiety and of

psychotic disorders such as schizophrenia and bi-polar affective disorder.

Psychiatric services are becoming concentrated on the care of those with 'severe mental illness,' largely (but unjustifiably) synonymous with chronic psychosis. The retreat of psychiatry from the care of those with non-psychotic mental disorders has helped the growth of counselling services for these patients.

(Wessely 1996, 158)

Wessely was concerned that the range of counselling approaches in use had yet to be proven effective, at a time when psychiatry was leaving the large number of patients with the more common mental health problems to counsellors, having itself to concentrate on keeping up with the demands to treat those with 'serious mental illnesses'.

1.10.7 Issues of communication and confidentiality between different sources of support

Counsellors, GPs and other non-academic supportive professionals work within ethical codes which include protection of the client's confidentiality. However, tutors and other staff often wish to have two-way communication with such professionals about students with mental health problems and this can cause frustration (Stanley & Manthorpe 2001, Bell 1996). Ethical codes of practice and the requirements of the Data Protection Act mean that information sharing has to be negotiated with the student-client, unless there are exceptional circumstances (Davies 2000). Parents often have a key relationship with their student offspring, but their role as supporters is apparently not explored in the research literature. Harvey (2002), writing of the experiences of parents of students who have committed suicide, says one key issue is that:

Frequently our children employ a massive cover-up that may include friends, tutors and family – even health care professionals... Sometimes we only discover later, maybe by chance, that our child has been taking anti-depressants for years, that they have made one or more suicide attempts of which we knew nothing.

... What seems to be missing from all our accounts is any real sense of partnership – of support services, tutors and parents being able to work together with a student in crisis.

(Harvey 2002, 68)

As the majority of students are legally adults it would seem that there is little that can be done in response to such parents' request to share information and worries about their student 'children' with university support services or health care professionals. However, the emphasis on confidentiality and the need to reduce suicide

risk present a very hard dilemma for all concerned.

Members of university/college staff who become aware of students with emotional or mental health problems have to decide whether they alone can support the student, or help them access other sources of help. Earwaker (1992) concludes that the older establishments expect a greater pastoral role from their staff whereas, in the newer institutions, academic staff are required to know who to refer the student on to rather than to deal with the students' problems themselves. Even where there is a clear pastoral role for tutors and others, staff have to decide when they have reached the limits of what they can offer. Such decisions are not clear-cut and will vary between staff depending on their ability to handle personal issues (Bell 1996).

One study in the further education sector (Scarborough & Hicks 1998) discovered that tutors were more likely to refer for counselling cases of depression rather than cases of anxiety or aggression and that males were generally considered to be in more urgent need of referral than females. The authors suggest that the latter finding may be the result of gender stereotyping. If tutors see it as normal for females and abnormal for males to be psychologically distressed, they may be more likely to take males' distress seriously.

These examples illustrate the need for staff training on mental health issues (Manthorpe & Stanley 1999a), not to turn academic staff into therapists, but to help them set appropriate limits to their involvement and to know when and where to refer students on for professional support.

1.10.8 The relationship between counselling and medical services.

Most authors agree with Newsome et al. (1973) on the importance of recognising the limits to what can be offered when dealing with mental and emotional problems presented by students. However, the boundaries between issues that can be handled by counselling services and those that should be referred for medical or more intensive psychotherapeutic services are not clearly defined and need to be negotiated. This negotiation is best conducted in the context of a good relationship between medical and counselling services. However, if as Bell (1996) believes the co-operative relationship between student counselling and medical services has diminished since the pioneering work of Nicolas Malleon in the 1950s and 60s, then work at the boundaries

of each service may be affected by rivalry and mutual suspicions.

Counselling services have developed a non-medical identity... and many medical practitioners feel that there is little time to support anyone but themselves and their immediate patients... One of the major tensions between counsellors and medical practitioners can be summed up in the phrase 'doctor knows best.'

(Bell 1996, 132).

With a proportion of medical practitioners placing little or no value on psychodynamic and person-centred approaches to counselling (Surtees et al.1998, Bell 1996, Ward 2001), collaboration across boundaries can be difficult to achieve.

A further complication, fuelled by NHS funding constraints, is that it can be hard to gain access to secondary level mental health care except in the most severe cases:

... There sometimes appears to be an implicit assumption that university counselling services will be able to make up for shortfalls in the provision of psychological treatment and support within the NHS. ...

Even where good liaison and co-operation between university counselling services, GPs and local psychiatric services exist, in some regions current NHS resources are such that unless a student is a danger to themselves or others, often the only provision immediately available is medication and follow-up appointments at comparatively lengthy intervals.

(Rana et al. 1999, 7)

Despite differences in theoretical orientation and professional practice, student counsellors generally feel safer working with the more distressed clients if they can compare notes on 'borderline cases' with a psychiatric consultant (Bell 1996, Rickinson & Turner 2002). A number of student counselling services have hired their own part-time psychiatric consultants who can both be consulted by counsellors to check out their own judgement and can provide direct psychiatric assessment of student clients (Bell 1996).

With different belief systems in place there may be ambivalence towards referring students to medical services even in the case of suspected psychotic disorders.

Student counselors who are properly informed about the limited efficacy of neuroleptic treatment – and its risks and side effects – can find themselves confronted with the 'damned if I do, damned if I don't' ethical dilemma over the decision to direct students into psychiatric care.

(Gosden 2001, 35)

1.10.9 Mental health promotion within universities and colleges

Recently some universities have appointed specialist staff with responsibility for student mental health issues (Rickinson & Turner 2002). These staff may not only co-

ordinate support for students with identified mental health problems, but may also be involved in mental health promotion, advising on changes in institutional practices.

The implications of a social model of mental health are that the effects of the academic institution upon the student must be reviewed (Earwaker 1992, Stanley & Manthorpe 2002). Student well-being cannot depend solely upon the student developing coping strategies and using support networks; external threats to their mental health have also to be addressed. Billing (1997) indicates some ways in which educational institutions can ease the transition of students into their organisations, particularly by ensuring that information is given out early enough and that students are supported through 'learning to learn' programmes which are integrated into course activities. Health-promoting universities (Tsouros et al. 1998) offer a model where the physical and mental health of staff and students is considered on an institution-wide basis.

Educational institutions can also help to provide students with skills which may reduce stress-related problems. One such measure is the development of stress management courses for students (Durbin 1992). However, more widespread initiatives to develop mental health awareness amongst students seem slow to get off the ground, despite various initiatives developed in conjunction with the National Union of Students (Wade 2002).

1.11 Summary and implications for research

The literature reviewed suggests that students are more likely to seek support for emotional and common mental health problems from family, friends or tutors than from professionals such as counsellors or GPs. It is possible that those who need help most are least likely to ask for it. Those who have accessed support from friends are more likely to seek professional help for more serious problems than those who have not.

Professional boundaries and issues of confidentiality between tutors, counsellors and medical practitioners can lead to mutual suspicion or resentment. Sources of informal support such as family and friends are also faced with barriers to communication with professionals. Student counselling services report that they are dealing with more psychologically disturbed students who are not able to access treatment from secondary care services at the time of need. At the same time many academic staff do not feel sufficiently trained or supported to respond effectively to

students with mental health problems. Guidance for staff tends to focus on how to obtain counselling, medical and other support for students but does not address good practice in providing enabling teaching and learning environments.

The issues raised can be related to Tyrer and Steinberg's (1999) theoretical model of social, psychological and bio-medical approaches to mental health which informs this research project. Most student distress is dealt with at a social level through the support of friends, family, tutors and other staff. A smaller proportion of students seek psychological help from counsellors or are referred to psychotherapy services. Other students will either choose to approach a GP for support or, owing to the serious impact of their mental health problem, be referred for medical treatment.

Students with emotional and mental health problems can have needs which could be addressed at different levels: social, psychological and medical. However, organisational and individual responses to these needs may be determined by adoption of particular approaches to mental health. Existing research literature does not explore how decisions are taken to seek support from social, psychological or medical sources. In none of the literature discovered has there been any significant exploration of how students' mental health needs are responded to by a range of organisations and services, spanning both the academic and healthcare fields. Nor has there been any work that explicitly covers the interaction of different models of mental health, although some authors explore the boundaries of appropriate involvement by tutors, counsellors and medical personnel.

The literature reviewed suggests some questions which can be investigated by this research project:

- a) What approaches to mental health are adopted by organisations, services and individuals involved in supporting or treating students with mental health problems?
- b) How do these organisations implement these approaches in their interventions with students?
- c) What are the resulting consequences of any differences in approach to mental health for the quality of support offered to students with mental health problems?
- d) What are the implications for the planning and delivery of co-ordinated support and treatment services to students?

Chapter 2 Research Design, Methods, Sampling and Analysis

This chapter describes how the research was carried out and covers the context, the research aims, the adoption of a case study design, development of a conceptual framework, ethical issues, sampling strategy, data collection, analysis and issues of generalisation.

2.1 The context of the PhD research project

The majority of the research for this PhD took place whilst I was employed as Project Manager/Researcher for the Oxford Student Mental Health Network (OSMHN), a project funded by the Higher Education Funding Council for England from June 2000 to June 2003 (see Introduction and Chapter 3). The HEFCE funding was given to map the provision of support for students in Oxford and to bring the providers of that support together within a collaborative network. This project provided access to the universities, colleges and healthcare trusts within Oxford. With the approval of OSMHN's Steering Committee, data were gathered to address the aims of both the funded project and the PhD. Both explored the support given to students with mental health problems in Oxford. Data analysis for the OSMHN project was conducted with an intrinsic interest in the institutional cases studied (Stake 2002) and was particularly focused on evaluation of the support structures provided. This analysis culminated in the production of an end of project report (OSMHN 2003) identifying the strengths and weaknesses of different sources of support and making recommendations for action. Data analysis for the PhD continued until March 2004 and took an instrumental approach to the institutional cases studied (Stake 2002), analysing the support offered according to social, psychological and medical approaches.

2.2 Aims of the investigation

This study set out to examine the nature of the support offered to students with mental health problems by academic, healthcare and other organisations in Oxford. Support is defined widely here to include formal and informal social support as well as psychological and medical treatment. The key theme underpinning the study was that people with mental health problems had needs which could be addressed at different levels: social, psychological and medical, whilst the support offered within different organisations might be determined by adherence to particular approaches to mental

health. Linked to this theme of support needs was the question of how people identified someone as having a mental health problem, and what factors they considered to contribute to the development of mental health problems. This study happened to be based on a student community and their supporters, as the OSMHN project offered the opportunity to gain access to this population. It could equally well have been carried out in an employment setting or a geographical community. However, the student community offers particularly good opportunities to study different types of support. In addition to the medical services available to the whole population, they have access to a range of social and psychological support e.g. specialist advisers and university counselling services, which are not likely to be replicated to the same extent in other settings.

The literature review confirmed that there are many different approaches to supporting people with mental health problems which could be fitted under the broad headings of social, psychological and medical. Previous studies of student communities had tended to focus on the support given by university staff, and to a limited extent by counsellors, and had a practical focus rather than exploring more theoretical or conceptual themes. Examination of the literature on the mental health of students and different approaches to mental health in general led to the development of the following research questions:

- a) What approaches to mental health are adopted by organisations, services and individuals involved in supporting or treating students with mental health problems?
- b) How do these organisations implement these approaches in their interventions with students?
- c) What are the resulting consequences of any differences in approach to mental health for the quality of support offered to students with mental health problems?
- d) What are the implications for the planning and delivery of co-ordinated support and treatment services to students?

These were the questions posed about each of the cases (Yin 1989) which in turn informed the content of the semi-structured interview questions (Appendix 1) and the subsequent analysis of the data.

2.3 Research design

The research design chosen was that of case study. The term refers here not to individual case studies of patients or service users, but to the study of organisations. Yin (1989) refers to case study as a methodological approach for researching organisations or particular situations, seeing it as particularly appropriate for the empirical investigation of a contemporary phenomenon (e.g. provision of support for students with mental health problems) within its real life context (i.e. universities, colleges and healthcare organisations) using multiple sources of evidence. By contrast Stake views case study in terms of what is being studied, the case, which he describes as a 'bounded system'. According to Stake: 'An institution, a programme, a responsibility, a collection or a population can be the case.' (Stake 2002, 23). In this research the cases studied were two universities, a college of further education, a primary care trust and a mental healthcare trust. Each institution was distinct from the others in their roles and responsibilities, but their populations overlapped to some extent e.g. a student could be supported by their university, the local primary care trust and the mental healthcare trust. For clarity of focus it was decided to make the case synonymous with the institution.

Case studies, rather than a survey, experimental design or participant observations seemed to provide the best structure for the research design. The nature of the research questions ruled out the use of highly-structured questionnaires with a choice of pre-determined answers. The intention was to find out how different individuals within organisations viewed mental health and made decisions about providing support. This required asking a series of open-ended questions to relevant individuals. Although it would have been possible to send out questionnaires with such questions, leaving blank spaces for respondents to record their answers, there would have been a number of drawbacks. The return rate would be likely to be very low, there would be no opportunity to clarify that the respondent had understood the purpose of each question, and there would be no possibility of asking follow-up questions to develop themes raised by the respondent. Observation of individuals providing support was ruled out for practical reasons. In the case of informal social support, even if it were possible to ensure that the observer could be in the right place at the right time, observation would intrude on the privacy of the individuals concerned. In the case of the support offered by psychological and medical practitioners, observation was ruled out by considerations of privacy and confidentiality and by the nature of the therapeutic relationship itself.

Case studies offer the chance to look at the roles of individuals within an organisational context. Stake (2000 & 2002) distinguishes between *intrinsic* case studies in which cases are studied for their own sake, and *instrumental* case studies which are conducted to learn more about particular phenomena or processes present in the cases being examined. Whilst the research carried out for the Oxford Student Mental Health Network could be described as intrinsic – based on the need to find out how well each organisation supported students with mental health problems, the research for this PhD was more instrumental in orientation – using each of the organisations studied to explore the differences between social, psychological and medical support. This instrumental focus is similar to Appleton’s interpretation of case study research:

[Case study is] an intensive analysis in which the inquirer attempts to examine and understand key variables which are important in determining the dynamics of a situation, in order to provide a detailed insight into a specific phenomenon of interest.

(Appleton 2002, 82)

When the purpose is to explore or develop theoretical constructs, the findings are strengthened by studying more than one case. Yin advocates such an approach which he terms ‘multiple case studies’; similarly Stake proposes the use of the ‘collective case study’. A collective case study is a form of instrumental study where a number of cases are studied ‘in order to investigate a phenomenon, population or general condition’ (Stake 2002, 437).

Case studies can employ both quantitative and qualitative research methods, but the latter is the most commonly used. Yin (1989, 1993) tends to take a more positivistic approach to case study research than Stake, emphasising the need to demonstrate a logical and rigorous approach. This is reflected in a very detailed and structured set of instructions for conducting case study research. Despite this quasi-scientific focus, Yin includes mostly qualitative methods such as interviews, observation and documentary analysis within the case study approach.

Although Yin and Stake take somewhat different approaches to conducting case studies, both agree that such studies can explore institutions, interventions, decisions and experiences. The work of both authors has informed the approach taken in this research. The structured approach suggested by Yin was initially attractive as it offered clear guidance on research design. The more pragmatic approach adopted by Stake turned out to be more realistic as it allowed for the flexibility required in the actual implementation of the research, a point which is developed in subsequent sections of this chapter. For the reasons mentioned earlier, direct observation was ruled out, but

face to face interviews supplemented by information derived from other meetings and documentary sources were all compatible with the case study approach.

2.4 Development of a conceptual framework and research questions

Both Stake (2000 & 2002) and Yin (1989) suggest that case study research needs to be underpinned by a theoretical framework. Yin suggests that the development of a 'preliminary theory' is one of the researcher's first tasks. Without that it would not be possible to select appropriate cases or to choose what specific features to investigate within a case. Similarly Stake states that a case study will have a conceptual structure, organised around themes or issues:

Issues are complex, situated, problematic relationships. They invite attention to ordinary experience but also to the language and understanding of the common disciplines of knowledge, such as sociology, economics, ethics, and literary criticism. Seeking a different purview from that of most crafters of experiments and testers of hypotheses, qualitative case researchers orient to complexities connected to ordinary practice in natural habitats to the abstractions and concerns of diverse academic disciplines.

(Stake 2002, 440)

For this research, debates in the fields of sociology, social policy, psychology and psychiatry were particularly relevant in identifying key issues. Information on models of, and approaches to, mental health was gathered through literature reviews, discussion with my research supervisors and pilot interviews with practitioners. I was also able to draw upon my own sixteen years' experience of working in the mental health and higher education sectors. This initial work helped me to identify the main features and relationships to be covered in the case studies. The idea of using categories of social, psychological and medical approaches to mental health in the analysis of the data was adapted from the models developed by Tyrer and Steinberg (1999). There was no evidence of any previous research of student mental health using this framework.

Yin (1989) distinguishes between different levels of questions used in case studies including: the questions that are asked when comparing cases, the questions that are asked about each case, and the questions that are addressed to individual participants. The four key research questions (see Section 2.2) were designed to explore and compare how mental health problems were addressed in each institution and whether the distinction between social, psychological and medical approaches to support was relevant to this. These questions, based on the conceptual framework that there are significant differences between social, psychological and medical approaches,

led to the development of more specific questions used in the individual interviews (Appendix 1).

2.5 Ethical issues

Ethical issues are particularly important when such a sensitive topic as mental health is under scrutiny. Ethical clearance for working with practitioners and clients was obtained from Oxford Brookes University School of Health Care's Research Ethics Officer and the Applied and Qualitative Research Ethics Committee (AQREC) which comes under the Oxford Radcliffe Hospitals NHS Trust. This provided a valuable template for identifying potential ethical problems, along with guidance for clear communication with potential and actual research respondents, so that those problems could be avoided. The letters, information sheets and consent forms supplied to respondents can be found in Appendix 1.

Some of the key ethical issues that were considered were:

- Being honest about the aims of the study – ensuring informed consent
- Representing respondents accurately
- Avoiding further distress for vulnerable respondents
- Ensuring anonymity and confidentiality
- Knowing how to deal with examples of risk or malpractice
- Maintaining appropriate boundaries
- Minimising disruption of respondents' work with clients.

The aims of the study were set out in the information sheet so that potential respondents were clear why they had been approached and to what research they were being asked to contribute. After reading the information sheet they had the chance to ask questions for clarification before signing the consent form (Appendix 1). All respondents were offered the opportunity to read through and comment on their interview notes and to receive a report on the research. In this way the chances of misrepresenting their views were minimised.

There was a slight risk that asking students to give feedback on a period when their mental/emotional health was challenged might provoke some re-stimulated distress. This risk was necessary, as it would not be possible to achieve a balanced picture of the mental health situation of students without consulting students

themselves. It was decided not to interview students who were known to be currently undergoing a mental health/emotional crisis. Questioning would attempt to focus attention away from how the student was feeling towards an evaluation of the support they received at the time of their ill-health. If the student did require further support as a result of the interview, the researcher would ensure that they had details of suitable support agencies. If there was any perception of risk of a student causing harm to themselves or others, or if professional malpractice was uncovered, the researcher would have consulted the OSMHN's project Director and academic research supervisors immediately. Fortunately this did not arise. Similarly a protocol was drawn up (Appendix 1) to ensure that interviews were conducted as safely as possible.

Another ethical problem could have been the creation of an expectation, on the part of the student participants, that the researcher would be providing them with some form of therapeutic support. For this reason it was important to explain that this was purely a research exercise and that any support needs must be addressed through the appropriate channels by the students themselves.

The mostly likely ethical problem to be faced was that of preserving the anonymity of respondents. This was addressed by coding any details that might reveal their identity, ensuring the security of the data collected and being careful about how data were reported. Respondents were given assurances about confidentiality and anonymity in the information sent to them prior to interviewing. It was important that respondents felt free to be as honest and critical as necessary in their comments without fear of any negative consequences.

Those whose lives and expressions are portrayed risk exposure and embarrassment, as well as a loss of standing, employment and self-esteem.

(Stake 2002, 447)

Another concern was that in asking staff to give time to be interviewed they would have less time to spend on client contact. This was particularly relevant to counsellors and psychiatric staff who all had waiting lists for their services and operated very full schedules. In view of this, agreement was reached with senior managers in different agencies and departments before individual staff were approached. Interviews were kept to one hour unless the respondent requested longer, and the researcher visited the respondents in their work place to minimise their time away from work. Although the practitioners interviewed were very busy, they appeared to value the opportunity to reflect upon their work and to contribute to a project which might improve the quality of support for their clients.

2.6 Sampling strategy

In case study research, sampling tends to be carried out by identifying cases which are relevant to important theoretical or conceptual questions rather than by finding a sample which is statistically representative of the general population (Yin 1989). In selecting the case, Stake advocates choosing those from which we can best learn. They may not be the most representative, but they are the most accessible and are the ones with which we can spend most time. ‘Isn’t it better to learn a lot from an atypical case than a little from a seemingly typical case?’ (Stake 2002, 446). Similarly, when choosing what sections of an organisation to study within individual cases, whilst issues of representativeness must be considered, access and acceptance are also important (Stake 2002). Considerations of accessibility were very influential in this research. The OSMHN project opened up the opportunity to access the major educational and healthcare institutions in Oxford. The two universities in Oxford were certainly not typical (if that is possible) of all universities in the UK, but they, along with the other institutions studied, did offer as good a chance as any to explore the distinctions between social, psychological and medical approaches to support.

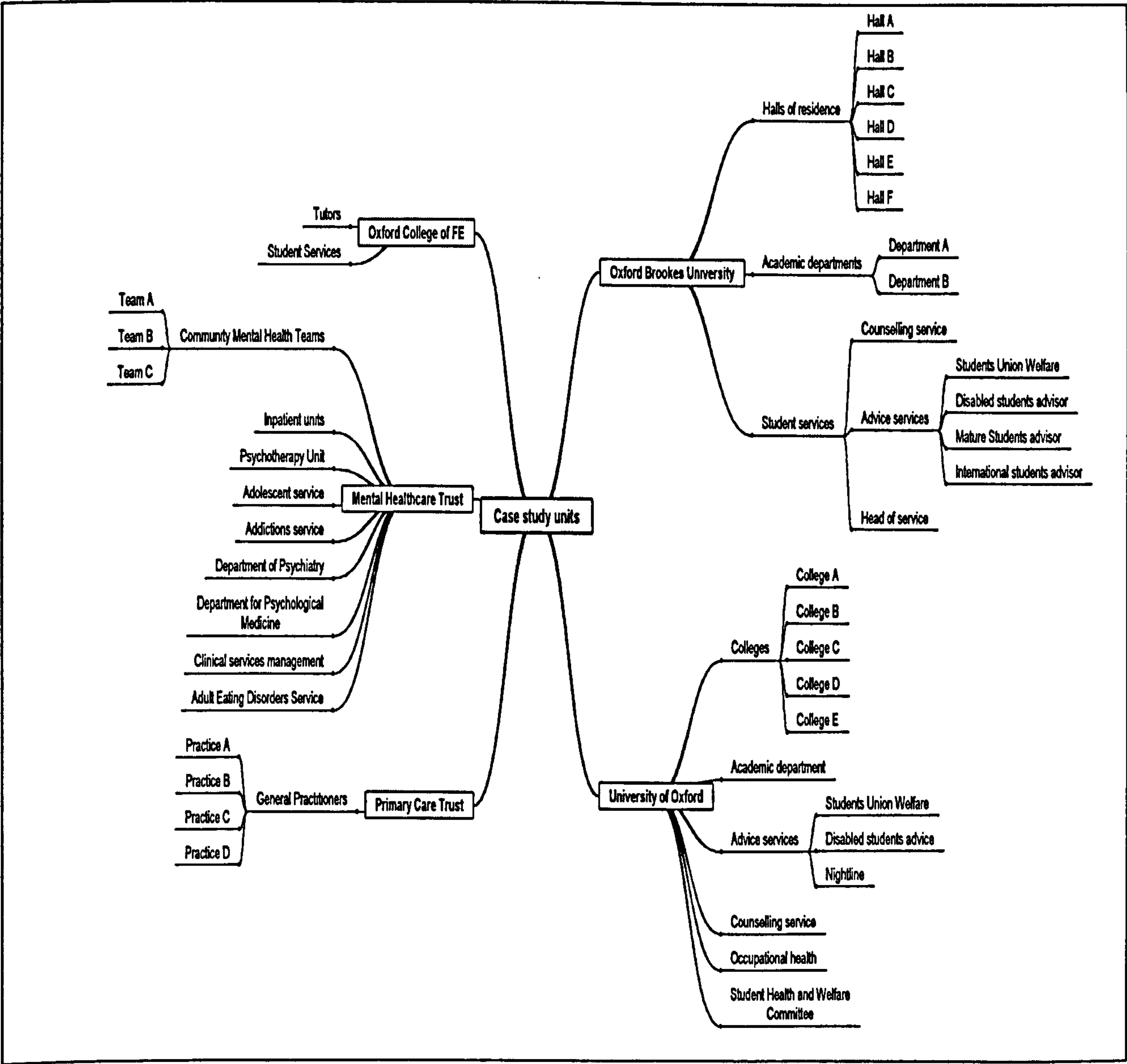
The main ‘cases’ studied were:

- Oxford Brookes University
- University of Oxford
- Oxford College of Further Education
- Oxford City Primary Care NHS Trust
- Oxfordshire Mental Healthcare NHS Trust.

Interviews with members of the Oxford Student Mental Health Network’s Steering Committee enabled identification of the main departments and agencies within these institutions which provided support for students with mental health problems. Certain agencies, e.g. the counselling services at the two universities, were represented on the OSMHN Steering Committee, which made access to their staff relatively straightforward. In the case of other agencies, such as the GP practices, purposive sampling was used in order to try to get a cross-section of experience e.g. practices which treated students at each university and those in the further education sector. At the secondary and tertiary levels of mental health services, there were a fixed number of teams, departments or wards involved in treating students as patients and each of these

was approached. Once contact had been established with individuals within agencies, they in turn were asked if they were aware of any other sources of support for students with mental health problems. As Oxford is a relatively small city, it did not take long to build up a relatively complete list of organisations and agencies. Figure 2.1 (below) shows the organisations and services which took part. It is set out in the form of a ‘mind map’ (Buzan 1995) which shows how the various sub-units of each case studied are connected.

Figure 2.1 Case study units included in the research¹



Those individuals within each organisation or department who had most contact with students were approached by letter, followed up by a phone call. The response rate to this was very high, with only nine people declining to take part or not responding to

¹ There is not an exact match between the units shown here and the interview respondents listed in Table 2.1 as this diagram includes units accessed by other means such as meetings connected to the work of OSMHN.

messages. Seventy-six individuals were interviewed. One interview, set up with a Community Psychiatric Nurse fairly late in the data collection process, fell through and unfortunately could not be rearranged. The main lack of response or refusal to take part occurred amongst General Practitioners. Only three GPs out of ten approached agreed to be interviewed, but between them these three covered students in both universities and the further education sector. This low rate of response has resulted in a less comprehensive coverage of Primary Care compared with university counselling services and secondary and tertiary mental health care services, where the response rate was close to 100%. Two University of Oxford colleges, one predominantly undergraduate the other exclusively post-graduate, were studied in depth. At Brookes a range of staff in academic, residential, support and advice positions were approached. The College of Further Education had a lesser degree of involvement with the OSMHN project and, given the time pressures on the researcher, this led to relatively minor coverage of this institution.

The sampling of individuals within the case study organisations was not used to find those with extreme views, e.g. very pro or anti the medical approach to mental health and illness. It would have not been easy to identify such individuals in advance of interviewing them. The intention was rather to explore the views of a range of people who had a significant involvement in offering support to students with mental health problems. Whilst practically all the university counsellors and community-based psychiatric consultants in Oxford were interviewed, only a small proportion of students, tutors, college staff, GPs and nurses could be included. Although this type of research was not particularly concerned with statistical representativeness, it must be recognised that in these latter groups the full range of views available may not have been explored. Nevertheless, towards the end of the interviewing process the data categorised had approached a point of ‘saturation’ with a wealth of relevant material collected and little or no new ideas or interpretations being generated by subsequent interviews. Table 2.1 below shows the range of respondents interviewed.

Table 2.1 Respondents interviewed in the organisations studied

Oxford Brookes University	University of Oxford	Oxford College of Further Education	Oxford City Primary Care NHS Trust	Oxfordshire Mental Health Care NHS Trust
1 Service manager 6 Counsellors 3 Student Advisers 7 Hall staff 4 Students 4 Tutors	10 Counsellors 5 College staff 1 Chaplain 6 Students 4 Tutors 1 Occupational physician 1 College nurse	1 Manager 1 Lecturer 1 Personal Adviser	3 General Practitioners	5 Psychologists / Psychotherapists 6 Psychiatrists 2 Nurses 4 Service managers
Total 25	Total 28	Total 3	Total 3	Total 17

2.7 Research methods and data collection

The case study approach forms an overarching research design or strategy. Within this framework a number of research methods can be employed. As mentioned in section 2.3, direct observation was not felt to be possible although it is commonly used in educational case study research (Wolcott 2001). In addition to the semi-structured interviews which formed the major source of data for this research, other sources of data were used including a postal survey conducted for the Oxford Student Mental Health Network and documentary analysis of various data including:

- Documents produced by the organisations studied
- Reports and other documents concerning mental health services for students in the Oxford area
- Notes from meetings held with individuals and groups as part of the work carried out for the Oxford Student Mental Health Network
- Notes from workshops and other events run by the Oxford Student Mental Health Network
- Notes from meetings and events run by other organisations
- Articles in newspapers and other publications concerning student mental health in Oxford.

The semi-structured interviews (see Appendix 1 for interview questions) constituted the main source of data for the case studies with the other sources of data providing background and corroborating information. A list of questions was drawn up

and tested out in six pilot interviews. The questions were subsequently refined and differentiated according to the role of the respondent, i.e. somewhat different questions were asked of staff working in halls of residence to those put to health service staff (see Appendix 1 for examples). The letter of invitation was accompanied by an information sheet (Appendix 1) which set out the purposes of the research, gave reassurances about confidentiality and anonymity, and provided details of the ethical clearances obtained. Before the interviews took place each respondent signed a Consent Form (Appendix 1) to say that they had read and accepted the terms of the information sheet.

During the interviews, I noted the responses to each question on a hand-held computer (I was able to maintain eye contact and record notes effectively as I can touch-type). As soon as possible after the interview, the notes were transferred to a desktop PC and typing errors were corrected. A copy was then sent to the respondent for them to make any further corrections or amendments. Appendix 1 contains an example taken from a typical length interview. There is a danger that the process of typing notes during the interview could be distracting or irritating to the respondent. This did not seem to be the case in this research, as there was a steady flow of thoughts and information from practically all of those interviewed. Nevertheless, most means of recording information involve some intrusion into the relationship between interviewer and interviewee, and negative effects of this method cannot be ruled out. In practice the main problem encountered was that of trying to keep up with certain respondents who were particularly enthused with the subject and spoke quite quickly.

Use of a tape recorder during interviews was considered but rejected for two reasons. Firstly, that it would inhibit respondents from discussing aspects of what can be a very sensitive topic. A number of respondents expressed relief that the interviews were not being recorded, and some wanted to make comments 'off the record'. Secondly, that the time taken to transcribe tapes would be prohibitive. As the intention was to capture the key ideas and experiences of the respondents, rather than engage in a linguistic analysis of the discourse, the amount of detail captured by the method used was perfectly adequate for data analysis to take place. Although it is also possible to allow 'off the record' comments by switching a tape recorder off, the fact that a tape recorder is running may inhibit respondents from making such requests. This is something that could perhaps be discussed at the start of a recorded interview. In this research such comments were not noted down, respecting the respondent's wishes, but had any important points been raised at such times, the main themes would have been logged at the end of the session. In practice this was not necessary, as such comments

tended to back up points already made with reference to particular individuals who the respondent feared might be identifiable.

Interviews typically lasted for an hour. In some cases all the questions were covered, in others they were not, either because they were not relevant or because there was inadequate time. In the latter case respondents had the opportunity to add comments when the initial interview notes were sent to them for review. Interviews typically generated around 1,500 to 2,000 words of interview notes, the shortest being 551 words and the longest 3,711 words. To preserve anonymity, each respondent was allocated a code, and references to particular departments, colleges or individuals were also coded. The system of asking each respondent to check and, if necessary, amend the interview notes helped to counter any danger of bias creeping in to the recording of the data collected. Of the 76 people interviewed, 19 sent back amended interview notes, either adding additional material and clarification of points made, or making minor corrections.

In each organisation studied, respondents were asked if they had any documentary evidence that could be shared, e.g. policies, reports, figures on service usage, leaflets, forms etc. Although these contained much less data than the research interviews, they did provide useful background information and the opportunity to corroborate some of the statements made by respondents. In addition to the research interviews, there were other contacts arising through the work of OSMHN (Figure 2.1). One-to-one meetings were held with another forty individuals and eight meetings with groups. Meetings were held with staff in two Health Centres/Medical Practices, one covering Oxford Brookes University, the other covering some of the Oxford University colleges. The notes from these meetings form part of the background case study evidence concerning local organisations, but are not quoted directly, as permission to do so has not been sought. The Oxford Student Mental Health Network held workshops on various aspects of student mental health (Appendix 1). The issues raised by speakers and those attending were noted and formed another source of background data.

The advantage of using semi-structured interviews to collect the main body of data for this research was the flexibility they allowed. Respondents were able to apply the interview to their own situations, giving long and detailed answers to some questions, whilst skipping over or giving briefer responses to those which felt less relevant. The interviewer was able to guide the respondent back to the topic if they strayed too far, whilst also being able to follow up unexpected leads. The interview

provided opportunities to respond to non-verbal clues and the tone of the respondent's voice which invited further probing on certain topics.

One danger of using interviews is that they depend on the skills of the interviewer. Robson (1993) summarises some of the main skills required in successful interviewing. The interviewer should: do more listening than speaking, ask questions in a straightforward and non-threatening manner, avoid leading questions, and finally appear to be enjoying the interview! Even when these skills are used, there is a danger that the respondent may try to give the interviewer what they think the latter wants rather than expressing their real opinions. This did not appear to be the case in this research where respondents seemed at ease and freely expressed their own opinions, but it should be borne in mind that interviews rely on what people *say* about what they think and do, and that this may not represent the whole truth. Another drawback to interviews is that they can be time-consuming to set up, carry out and write up, but this is compensated for by the richness of the data produced.

2.8 Analysing the data

The analysis of qualitative data is a complex area. The interviews for this research resulted in interview notes totalling somewhere in the region of 150,000 words. Alongside this were documents and notes from other meetings comprising several thousand more words. At a simple level, analysis of such data means reading through each record or document, reflecting upon it and making notes or diagrams of the key themes. The desire to make qualitative research appear more like a science than an art has led to various attempts to treat qualitative data in very formal and systematic ways. In the literature there are suggestions of listing, categorising and counting the incidence of certain key words (Ryan & Bernard 2002) which come very close to quantitative approaches. Grounded theorists suggest that each chunk of data is coded, categorised and eventually linked to developing emergent theories (Charmaz 2002). Such an approach differs from that advocated by Yin (1989) who believes that case study data should be analysed in relation to the theoretical concepts which underpinned the research.

A case study produces a large amount of data. Without some guiding framework, e.g. predicted relationships or meanings based on theoretical concepts and knowledge of previous research, Yin believes that analysis can become stalled. In Yin's approach, the data is examined to see if it matches or differs from expected patterns. He suggests use of a 'replication logic' in which the results of investigation at

one site, or institution, are backed up by findings from other sites, all of which serve to confirm or challenge the theoretical ideas under investigation. An alternative but less desirable approach, in Yin's view, is to produce a descriptive account of the cases studies, grouping data under various headings linked to key features of the case.

Stake is more open to the construction of meaning from the data gathered, but his approach is not so different to that taken by Yin in that he recognises that the case study will have a conceptual structure.

Local meanings are important; foreshadowed meanings are important; and readers' consequential meanings are important. The case researcher teases out meanings of these three kinds and, for whatever reason, works on one kind more than the other two. In each case, the work is reflective. (Stake 2002, 445)

Within Stake's approach, issues can arise and be reflected on at any stage of the research: planning, data collection, analysis or report-writing. Whereas Yin suggests that any significant shifts in theoretical understanding should prompt the researcher to start over again with a new set of case studies, Stake is more flexible (and probably realistic) in believing that such shifts can be accommodated.

The analysis of the data collected in this research was guided by looking for answers to the original research questions, whilst being open to the emergence of unexpected patterns and relationships. After the first year of conducting interviews and meetings, data from the different organisations studied was compared for similarities and differences. There appeared to be little value in counting the number of times that certain words occurred within interview notes, as respondents expressed their ideas using many different terms, and in any case these were not verbatim transcripts and would not accurately reflect the quantitative aspects involved.

The theoretical framework suggested certain avenues for exploration. In reading through the interview notes and other sources of data, the four key research questions were kept to the fore so that it could be seen what answers were contained in the data. At the same time it was important to be open to any themes which emerged. One method used for identifying key themes and their inter-relationships was the creation of 'mind maps' (Buzan 1995). These were drawn whilst reading the data, noting issues raised and attempting to make links between them. As more data were explored, categories were added or combined. At each stage these developing categories were discussed with my research supervisors using examples of the data categorised under each heading. This process continued until a fairly stable set of categories was agreed upon. The result was the creation of the ten data categories illustrated in Table 2.2.

Further details of the issues raised under each category heading are given in Appendix 1.

Table 2.2 Data categories used during analysis

1. Types of mental and emotional problems mentioned	7. Institutional factors. The impact of institutional culture, structure and practices on students' well-being
2. Beliefs about causes of students' mental health problems. Respondents defining mental health problems – what is a mental illness?	8. Academic factors. The impact of academic life and demands on students' well-being
3. Help-seeking behaviour	9. Personal roles. Particular issues for individuals who provide support
4. Nature of support available. Descriptions of the support given by individuals and services	10. Stigma and discrimination. The effects of stigma on disclosing and living with a mental health problem
5. Access and referral to the respondent's service	
6. Interagency issues. Working across organisational boundaries, collaboration, inter-professional difficulties	

Once the main categories had been established, sections of data (usually paragraphs or a few sentences) were assigned to them (examples can be seen in the Appendices accompanying Chapters 3 to 5). During the process of analysis there was a tension between breaking up the data so that statements from different sources about a particular topic (e.g. attitudes towards seeking help) could be brought together for comparison, as opposed to looking at the totality of what was said within an interview. Both proved to be necessary. Dividing the data into categories was useful for identifying emerging themes, whilst looking at individuals' responses, grouped according to their institution, helped to determine personal and institutional differences in relation to those themes.

During the data analysis, the two universities, the College of Further Education and the two health care trusts each formed a separate case study for reporting (Chapters 4 & 5). The different departments and services contained within each institution were viewed as units of analysis within the case, each with their own distinctive practices and areas of responsibility, but contributing to the picture of the whole. The categorised data, the whole interview transcripts and documentary evidence were examined in relation to each of the five organisations used as a case study. In addition, the pre-determined categories of social, psychological and medical approaches were used to distinguish between different types of support given.

The data analysis approach adopted seemed to be effective in that data were not broken up into meaninglessly small units, but was categorised in such a way that the initial research questions could be addressed. This approach sits somewhere between the grounded theory method of coding data and then identifying emergent themes, and

the approach advocated by Yin (1989) of using pre-determined conceptual structures to interrogate the data. It is closest to Stake's approach (2000 & 2002) which allows for what he calls 'foreshadowed meanings' whilst recognising that the meanings held by the research respondents and developed by the researcher will also be influential. In any analysis of qualitative data it is difficult to ensure complete impartiality or objectivity. What can be achieved, however, is a description of the processes used and examples of the data involved, so that others can make their own judgements about the validity of the findings.

This approach could be criticised for trying to make the data fit into categories which suit the researcher's purposes. To some extent this is inevitable, as a case study generates so much information that only some of the possible findings can be reported. What is important is to be open to discovering findings which are contrary to those which were expected. For instance, in this case there was an expectation that respondents from different professional and lay backgrounds would hold quite divergent views on the causes of mental health problems. In practice, analysis of the interviews showed that they were more likely to share a common framework of understanding about possible causation, and where they differed was in the type of support they could offer.

2.9 Generalisations and the case study method

There has been a debate in the literature on the extent to which it is possible to generalise from the results of individual or multiple case studies to similar organisations or situations in other contexts (Gomm et al. 2000). Lincoln & Guba (2000) suggest that the aim should be 'particularisations' rather than generalisations, the latter only being developed, if at all, as a 'working hypothesis' late-on in the process. They see generalisations as being too deterministic, and if they are to apply in different contexts of time and place, too general to be of practical value. Instead they favour descriptive accounts of the features of the case and its context. 'Thick descriptions' of one case will allow an inquirer to compare it with another and, if the contexts are similar, to try applying the working hypothesis to that new case.

Whilst statistical generalisation has generally been seen as inapplicable in case study research, other types of generalisation have been advocated. Yin (1989) recommends 'analytic generalization'.

In analytical generalization, the investigator is striving to generalize a particular set of results to some broader theory.

(Yin 1989, 44)

According to Yin, cases may either confirm the predictions derived from the underpinning theory ('literal replication'), or produce contrary results for predictable reasons ('theoretical replication'). The theory used needs to predict the conditions under which the expected results either will or will not be found. The latter point is somewhat confusing in that if there are 'predictable reasons' why one case would produce different results to another, then surely that is not a contrary result.

As discussed in the previous section, Stake (2000 & 2002) does not give underpinning theory such a key role, but he does acknowledge that researchers will approach their cases with certain expectations. He believes that it is important to seek out the 'emic' (internal) meanings held by participants, whilst acknowledging that in the end it will be the researcher who decides what to report. Generalisation occurs by providing sufficient information for readers to make comparisons with their own direct experiences and their reading of other case study reports so they can experience 'naturalistic generalization'.

Naturalistic generalizations develop within a person as a product of experience. They derive from the tacit knowledge of how things are, why they are, how people feel about them, and how these things are likely to be later on or in other places with which this person is familiar. They seldom take the form of predictions but lead regularly to expectations.

(Stake 2000, 22)

Donmoyer (2000) doubts that the social sciences can produce the deterministic laws and predictions found in the generalisations produced by physical scientists. He develops Stake's theory of naturalistic generalisation with an adaptation of Piaget's 'schema theory'. He proposes that a case study can provide 'vicarious experience' to the reader which enters their knowledge whilst being shaped by their existing cognitive structures, a process termed 'assimilation'. This is accompanied by 'accommodation', in which the person's cognitive structures are re-shaped by the additional information they have received.

After the dual processes of assimilation and accommodation have occurred, Piaget's theory indicates, a cognitive structure will be both more *integrated* (a particular structure will accommodate more things) and more *differentiated* (a particular structure will be divided into substructures).

(Donmoyer 2000, 59)

The advantages to the individual of going through these processes are that they will be able to perceive and interpret situations more richly and be able to act more

intelligently. Whilst policy makers may still need predictions of the behaviour of large sections of the population, Donmoyer suggests that individuals working in fields such as education, social work and counselling will derive more benefit from reading case studies which promote the development of their cognitive processes.

Wolcott (2001) advises caution over claiming too much when reporting on qualitative research and suggests a format that covers: what has been attempted, what has been learned and what new questions arise. A similar approach has been taken in this research, which provides descriptions of the different types of support available in each of the cases studied and offers a theoretical framework which categorises that support under the headings of social, psychological and medical approaches to mental health. Readers of the research findings presented may use them in different ways, whether their interest is personal, institutional, academic or relating to social policy issues. The relationship between these findings and the broader context of theoretical and policy issues is explored in Chapter 6.

2.10 Summary

A case study approach was adopted for this research and five organisations were studied. Within that framework, the main method of data collection used was semi-structured interviews. Other data came from meetings and documents. There was an attempt to include examples of all the major providers of support in the research sample. Sampling was linked to the theoretical concepts under investigation rather than statistical representation of a larger population. The research data were analysed using categories developed from the underpinning theoretical concepts and from themes emerging from the data itself. The resulting findings were written up on a case by case basis, enabling readers to decide if the results could be generalised to other situations with which they are familiar.

Chapter 3 Findings: The Local Context of Mental Health Support for Students

This chapter describes the local context of this research project between September 2000 and March 2003: the universities and colleges in Oxford, the provision of health care, views on the nature and causes of the emotional and mental health problems encountered, and attitudes towards seeking help. Subsequent chapters explore the nature of the provision of social, psychological and medical support for students in Oxford within their educational institutions and by healthcare services. (Details of the structures of the organisations covered in the case studies have been given in Chapter 2, Figure 2.1).

3.1 Demographic details

During the research period students made up a considerable proportion of the city's population. According to the Oxford City Council's web site:

The City has a diverse population of 134,248 people including an estimated 20,000 students ... It has twice the number of 16- 24 year olds than the national average; this is likely to relate to the size of the student population.

(<http://www.visitoxford.org/oxford/council.nsf/pages/DataandR103926.html> accessed 12.12.02)

Oxford City Primary Care Trust stated that:

We cover a population of approx. 196,000

Our population of young people (aged 16-24) is twice the national average, standing at 20%.

(http://www.oxfordcity-pct.nhs.uk/facts_&_figures.htm accessed 12.12.02)

The discrepancy between the two population figures is accounted for by the fact that the Oxford City PCT covered a number of surrounding villages as well as the City itself. The City Council's estimate of 20,000 students was likely to be an underestimate, as the figures given by the two universities in the City showed that for the academic year ending 2001 they had over 33,000 students registered (see Table 3.2). In addition there were a further 3,800 full-time students at the Oxford College of Further Education, Ruskin College and Plater College.¹

¹ Oxfordshire Health Promotion. *Oxfordshire Student Health Improvement Plan 2002.*

3.2 Local Higher and Further Education providers

This research included the two universities in Oxford, and to a lesser extent the College of Further Education. Setting aside the provision of support services, which will be covered in Chapter 4, the two universities were very different in many aspects as indicated in Table 3.1 below:

Table 3.1 Comparison of the two universities in Oxford²

	University of Oxford	Oxford Brookes University
Entry Requirements for undergraduates	Very high standard expected, a minimum of 3 A's at A-level plus evidence of further potential	Varied between courses; mature students could enter without A-levels
Structure	Decentralised structure with 39 separate colleges linked by a central administration authority	Centralised structure which operated over three main campuses
Status	Long-established (over 800 years old) prestigious institution	Former polytechnic, now rated best of the 'new' universities
Degree programmes	Undergraduate programme by full-time study only Full and part-time postgraduate courses Research degrees	Modular undergraduate and postgraduate degree programmes, by full- and part-time study Research degrees
Tutorial Support.	Tutorial system played a major part in teaching and learning and in pastoral care Staff : student ratio of 9.7 : 1	Tutorial support was available, but played a minor role in teaching, learning and pastoral care Staff : student ratio of 23.1 : 1
Accommodation	Majority of undergraduates were housed within colleges for all or part of their time at university.	2,500 students approximately were housed in halls of residence for their first year only.

The Oxford College of Further Education offered a wide range of courses, from those covering leisure interests to vocational and academic subjects up to Diploma level. The majority of students were drawn from the local population, although there were some international students at the college. Ruskin and Plater colleges offered further and higher education to a much smaller number of people who were typically entering as mature students often without formal academic qualifications. Complete demographic details of all the students in Oxford were not available, this was particularly the case for the smaller institutions. Table 3.2 provides a summary of the available information.

² Based on information from research interviews 2000-2003, Oxford Student Mental Health Network meetings, universities' own publicity materials and Times Guide to Universities 14.9.03.

Table 3.2 Demographic details of students in Oxford³

Institution 2000-2001	No of students	Male	Female	Under-graduate	Post-graduate	Entry Age>25	Inter-national	Full-time
University of Oxford	16,185	9,303	6,882	10,978	4,931	Not available	3,276	Approx. 16,000
Oxford Brookes University	17,703	7,543	10,160	12,640	4,744	9,770	3,611	9,648
Oxford College of FE	Approx. 16,000	Not available	Not available	0	0	Not available	Not available	Approx. 2,500
TOTALS	49,888			23,618	9,675			28,148

3.3 Providers of health care and other support in Oxford

Diagram 1 in Appendix 2 shows the range of support pathways available to students in Oxford. These sources of support include both those available to students as part of the local population, and those which have been set up specifically for students. More details of these sources of support is given in Chapters 4 and 5.

3.3.1 Support for students as part of the local population

Primary care in Oxford City was provided by 28 independent medical practices/health centres funded and co-ordinated by the local Primary Care Trust. Roughly one third of these, situated in central and north Oxford, tended to take the majority of University of Oxford students through individual arrangements with each college. Approximately half the students at Oxford Brookes University were registered with one large health centre in east Oxford⁴. Previously under the GP fund-holding system, this centre was able to employ mental health specialists. With the reorganisation of services under a Primary Care Group (subsequently becoming a Primary Care Trust) in 1999, the health centre was no longer able to fund this provision. There were two counselling services available at the primary care level: the Isis Counselling Service and the Primary Care Counselling and Psychotherapy Service.

³ Information from: University of Oxford Annual Report 2000-2001, Oxford Brookes University Annual Report 2000-2001, Oxford Student Mental Health Network interviews with Oxford CFE staff 2001.

⁴ Information from Oxford Student Mental Health Network interviews and survey of service providers

Prior to the local health re-organisation, a group of clinicians from the local Mental Healthcare Trust (Gelder et al. 1995) surveyed local GPs on the provision of mental health support for students. They found that most respondents were satisfied with services for severely mentally ill students, but were seriously concerned about access to services for acute problems, neurotic and personality problems, severe eating disorders and long-standing family problems. The GPs suggested that there was a need for timely access to psychological services, for psychiatric staff with knowledge of student issues and fast access for psychiatric assessment. Although these suggestions and others were formulated into an action plan to introduce services more closely linked to the student population's needs, these changes did not come about. During the research period there was no specialist provision for students in Oxford.

At the start of the research mental health promotion was the responsibility of Oxfordshire Health Promotion (part of Oxfordshire Health Authority) who employed a mental health specialist. The unit was involved in developing a draft Student Health Improvement Plan for the county, but was disbanded in 2002 before the plan could be implemented. Health promotion activities were devolved to individual Primary Care Trusts, and the mental health specialism was discontinued. Subsequently Oxford City Primary Care Trust (PCT) convened a Local Implementation Group which was responsible for the implementation of the National Service Framework standards for mental health. The PCT was also responsible for commissioning secondary and tertiary mental health services for residents of the city.

The Oxfordshire Mental Healthcare NHS Trust provided secondary and tertiary mental health services in the locality (see Chapter 5). Although there was no specialist provision for students, one Community Mental Health Team (CMHT) and a few wards in each of the two local psychiatric hospitals tended to see the majority of students who experienced severe mental health problems.

Voluntary sector provision of mental health services included day-centres, befriending schemes, rehabilitation workshops, supported housing and advice centres. Many of these services were targeted at people who had experienced mental health problems for many years, and were less likely to be used by university students. However, some users of these services did enter further education and occasionally higher education (Chapter 5).

3.4 The Oxford Student Mental Health Network

A forum for meeting and exchanging ideas was provided by the Oxford Student Mental Health Network (OSMHN) for the various institutions and agencies supporting students with mental and emotional problems in Oxford. Launched in June 2000, it was funded for three years by the Higher Education Funding Council for England (HEFCE) and was a partnership between Oxford Brookes University, the University of Oxford, Oxford College of Further Education, Oxford City Primary Care Trust and Oxfordshire Mental Healthcare NHS Trust. The Network employed a part-time Director, a full-time Project Manager/Researcher and a part-time Administrator (for more details see Appendix 2). It was through the opportunities provided by this Network that this PhD research project became possible.

The Network held two major events to which a wide range of people were invited including student representatives, users’ groups and voluntary sector organisations. In addition, OSMHN ran workshops and met with staff and students in the educational establishments, and with staff in the healthcare organisations. OSMHN produced a termly newsletter, a printed student mental health guide and a web-site providing information on student mental health issues. As a result of the partnership with OSMHN Oxford City PCT incorporated a section on student issues into its implementation plan for the National Service Framework for mental health. Also in collaboration with OSMHN, primary care guidelines on student mental health were developed for practitioners.

3.5 Incidence of mental health problems

No statistical information was available on the incidence of mental health problems in the local student population. Public Health estimates of the weekly prevalence of neurotic mental health problems in the population of Oxfordshire as a whole suggested the following levels:

Diagnosis	Rate per 1,000
Mixed anxiety and depression	61
Generalised anxiety	28
Depressive episode	12
All phobias	20
Obsessive compulsive disorder	6
Panic disorder	5
(Griffiths 1999, 7)	

The annual prevalence of functional psychoses (mainly schizophrenia and bipolar disorder) and of drug and alcohol dependence in Oxfordshire was estimated as follows:

Diagnosis	Rate per 1,000
Functional psychoses	5
Alcohol dependence	40
Drug dependence	27

(Griffiths 1999, 7)

A survey of students at Oxford Brookes in 1996 (Wyville-Staples P et al. 1998a) found that they were more likely to be affected by emotional problems than an age-matched sample in the general population, but did not provide data on the incidence of clinically-recognised problems. More recently, as Table 3.3 below shows, many FE students in Oxfordshire were found to have experienced emotional or mental distress.

Table 3.3 The mental health of further education students in Oxfordshire

<p>In a recent (2002) survey of Further Education Students in Oxfordshire</p> <ul style="list-style-type: none">• 26% had experienced intrusive emotional or psychological problems this term• 46% had experienced intrusive emotional or psychological problems in the past• 13% had thought that life was not worth living in this term• 6% said that they had harmed themselves this term• 6% thought about taking their life this term• 2% said that they had attempted suicide this term• 9% said that they had attempted suicide in the past <p>Schools Health Education Unit 2002 Further Education Student Health and Lifestyle Survey – Summary Report for Oxfordshire Colleges Exeter: SHEU</p>

3.6 Local views on mental health and seeking help

In large organisations such as those studied, it is not possible to represent the totality of views that will exist. The intention is to represent the views of those interviewed and, in combination with other forms of data such as documentary evidence from their organisations, see if the distinction between social, psychological and medical approaches to mental health is a useful one in these contexts.

3.6.1 Views about mental health and illness

It was possible to categorise the various providers of support within the categories of social, psychological or medical approaches to mental health, based on

their job or life roles, however the same could not be said of each individual’s views on the nature of mental health problems and their appropriate treatment. Even in the carrying out of work roles there were occasionally overlaps between categories e.g. some medical practitioners also used psychological interventions. There were psychiatrists and doctors who were very aware of social and psychological factors, students and academic staff who saw genetic/biological factors as playing a part, and counsellors who acknowledged the impact of social factors.

From the literature reviewed, it has become obvious that there are many views on what constitutes mental health and mental illness, and on what the causes of mental health problems might be for an individual. Those interviewed for this research rarely expressed a clear theoretical formulation of what defines mental health/illness, but they were able to describe thoughts, feelings, experiences and actions which might indicate mental health problems. These are summarised in Table 3.4.

Table 3.4 What indicates the presence of mental health problems amongst students?⁵

Behaviour Making bizarre statements Fabricating stories Attention-seeking Being insensitive to others Self-harming Attempting suicide Withdrawing Having poor social skills Displaying aggression Being disruptive Showing strange behaviour Committing dangerous acts Manipulating others Having poor personal hygiene Excessive drinking Participating in drug abuse Having problems with food Being obsessive	Feelings Panic Lack of motivation Not being in control Depressed Anxious Mood swings Overwhelmed Loneliness Lack of confidence/esteem
	Thoughts Paranoid Out of touch with reality Not caring what others think Strange beliefs Of life not being worth living Flitting/disconnected

⁵ Based on research interviews 2000-2003

Behaviour (continued)	Experiences
Showing poor time management	Hearing voices
Breakdown in functioning	Having visual hallucinations
Being unable to get out of bed	Being fatigued
Not being able to relax	Not sleeping
	Having volatile relationships
	Having difficulty in working
	Being cut off from feelings
	Having catatonia

The above is a summary of responses from those interviewed across all the organisations studied. There were similarities across each institution, but also some difference in emphasis. Within the University of Oxford, college staff tended to be aware of strange or eccentric behaviour which indicated probable psychotic problems amongst students. Counsellors, not surprisingly, were more aware of the inner conflicts and feelings experienced by students. Students themselves were particularly aware of the more common disorders related to stress.

I have seen a lot of mental health problems. Depression is number one in terms of frequency and duration. Many students will have some period of depression during their studies. As well as depression, anxiety and stress are the most common problems.

Student Welfare Representative OXU S06 39-45⁶

During the course of the research project the University of Oxford developed a Mental Health Policy available to staff and students on the University's web-site which sought to distinguish between more and less severe problems.

It is important not to label as a 'mental health' problem what are in reality normal emotional reactions to new experiences. However, a small number of students may experience emotional or psychological difficulties which are more persistent and which inhibit their ability to participate fully in higher education without appropriate professional support. These difficulties may take the form of a long-term mental illness or a temporary, but debilitating, condition or reaction.

(<http://www.admin.ox.ac.uk/shw/mhpol.shtml> accessed 23.10.02)

Most interviewees in all the organisations studied were able to distinguish between the more common emotional and mental problems which they typically associated with stress, and the more severe problems which were often seen to come from the individual's own biological or psychological make-up.

⁶ In all quotes from respondents, the code for each individual is followed by the numbered lines used in each of the interview transcripts.

I tend to say that the symptoms of anxiety, stress and depression can be resolved to some extent by finding someone who cares about you and accepts you as you are. This is not to say that serious mental illness caused by biological factors should be left untreated and clearly treatments such as medication and counselling can help. In the middle range, however, a proper emotional support system is needed and can do a great deal towards helping.

Student Welfare Officer OXU S06 104-108

Residential staff at Oxford Brookes University were very aware of behavioural difficulties amongst certain students which they saw as signs of severe mental illness. They varied in the extent to which they were aware of less dramatic presentations. In interviews they would typically offer the most striking examples of odd behaviour encountered, but when questioned further would also mention examples of students who were depressed, withdrawn and anxious (see Appendix 3.1). The counselling staff at Brookes were aware of a wide range of mental health problems in the students they encountered. In common with their counterparts at the University of Oxford counsellors were more likely to be aware of problems through the students' reported feelings and thoughts, rather than by observing disturbing behaviour. Amongst the students interviewed at Brookes, one (who had their own experiences of mental health problems) distinguished this from the stress experienced by others.

I have seen good friends experience times of stress and anxiety, but would say that they have mental issues not mental health problems.

Student OXB S03 71-72

Oxford Brookes University produced a handbook for staff '*Supporting Students*'. This mentioned 'mental health difficulties' and 'mental health problems' but did not define them. However, it had sections on 'Dealing with problems' and 'Responding to students at risk', which indicated the types of behaviour that staff should be looking out for.

Health care staff at a primary care level were likely to see a diversity of mental health problems amongst their student patients. As GPs were the gateway to secondary (psychiatric) care, they encountered students with serious mental health problems, but would also see those with more minor issues (Chapter 5). In the instance of more severe problems, a member of university or college staff might strongly recommend that a student sees their GP, and in the more extreme cases they might contact a GP directly either with or without the student's agreement. The GPs interviewed mentioned possible social, psychological and biological causes or triggers of their patients' mental health problems. However, other GPs may have been less interested in the non-medical aspects of their patient's presentation.

Some students have said ‘we are taking these antidepressants but feel fine in the holidays’. So it is clear that the problem is about not coping with the demands of life here at University. Antidepressants may not do anything because the pressure is still there e.g. the three essays that have to be written. In raising this I am aware of the issue of not being medically trained and have to be careful not to show shock when students raise this, but I find myself questioning the prescribing first policy.

Counsellor OXU 012 163-174

Owing to the nature of their role, staff at secondary and tertiary levels only saw those students with severe problems, conditions which would attract a psychiatric diagnosis. Nevertheless the practitioners interviewed were aware of elements of their patients’ conditions that went beyond the medical and psychological domains.

Mental illness amongst young people seems to be increasing, the service is getting more referrals. There is more awareness, but it seems that there are actually more problems in the community. This could be linked to: increased use of drugs and alcohol, family breakdown, unemployment and less stability in families.

Psychiatrist NHS 022 75-81

3.6.2 Views on the causes of emotional and mental health problems

There are a lot of factors in a mental health diagnosis. Contributing factors may be biological, neurological, life events such as: grieving, drug taking, accidents, divorce, moving house. You have to look at the person’s social situation.

Student OXB S02 77-79

The literature reviewed indicated that one way of differentiating between social, psychological and medical approaches to mental health lies in their identification of the aetiology (causal mechanisms) of mental health problems. Using Goldberg and Huxley’s (1992) schema of diathesis and stress, factors identified by research participants have been divided into vulnerability factors (Tables 3.5-3.7) and stressors (Tables 3.8-3.10). These have been further divided into social, psychological and biological/medical categories (Appendix 3.2 gives some examples of the statements on which these are based).

Table 3.5 Social causes of students’ mental health problems: possible vulnerability factors⁷

Family experiences Experiencing bereavement Parental divorce/separation Experience of abuse Affected by poor relationships Having a family history of mental health problems Traumatic incidents Experiencing accidents Having been attacked Moving house	Previous school experiences Having an overly-structured experience Having been bullied Being used to being the best in class Skills development Lacking social skills Having poor academic skills Having poor coping skills Not coping with freedom from parents Not being used to talking about feelings
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The boundaries between these social factors and others was not always distinct. A family history of mental health problems could be seen as either an indication of a genetic tendency or of the effects of growing up in the presence of distressing family relationships and behaviour. Many of these factors are best described as social-psychological as they often represent an interaction between the individual and their social and familial environment. The experience of parents divorcing once their offspring had left home for college or university was mentioned by several respondents as having a negative impact on students’ mental health.

It is a common age for a student’s parents to split up. Once the child has left for university the parents say ‘now we can split up’. They think it won’t have an impact but in fact it can be worse than if they’d split up when the student was at home. The student can feel responsible and powerless.

General Practitioner NHS 004 84-87

Many psychological factors were cited by respondents, and not just by professionals providing psychological support. There was a widespread lay-understanding of the factors which were seen to have a negative impact on students. Some, such as the drive for high achievement and perfectionism, were given specifically in relation to the personality of some students at the University of Oxford.

High achievers put pressures on themselves. I think it has something to do with comparing themselves to others and feeling they are not good enough to be here. Some are under huge pressure from their families, especially when they have grandparents or parents who have been to Oxford.

Student Representative OXU S04 107-111

⁷ Based on research interviews 2000-2003

Some respondents within the University of Oxford and the health services suggested a link between unusually high levels of academic intelligence and mental instability for certain students.

Some students are so clever that they are over the top mentally.
College Staff Member OXU 018 67

Is there any validity in the concept of the ‘mad genius’? There can be something about deep thinking and instability but it is bit of a myth.
Clinical Psychologist NHS 020 98-99

Other issues were seen as common to all students e.g., issues of development and transition.

Barriers get pushed by students as they are free for the first time from their parents and that can be the start of them exhibiting strange behaviour. They don’t know how to behave with the freedom and can be frightened of it. It can be quite disabling.
Hall of Residence Staff Member OXB 016 232-234

Table 3.6 Psychological causes of students’ mental health problems: possible vulnerability factors⁸

Personality Having a drive for high achievement Putting oneself under pressure Being affected by perfectionism Having a tendency to procrastination Deep thinking which is linked to instability Being overly-intellectual Struggling to develop a separate identity Losing a sense of one’s own identity	Emotional development Lacking psychological separation from parents Being cut off from feelings Having faulty family constructs Carrying emotional 'luggage' Showing unconscious rebellion Having long-standing unresolved issues Being insufficiently grown-up Having been affected by working hard for school exams during adolescence
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There were many fewer biological or medical factors given by respondents. Although General Practitioners and psychiatrists were particularly aware of these, social and psychological supporters also mentioned such factors as a possible cause of vulnerability.

If someone comes with depression I will say that there is a physical aspect to such conditions and there is no shame in seeing the Doctor or Nurse, or if is too serious I will recommend seeing a counsellor.
Chaplain OXU 017 69-71

⁸ Based on research interviews 2000-2003

Table 3.7 Medical/biological causes of students’ mental health problems: possible vulnerability factors⁹

Genetic factors Affected by genetic inheritance Possible neurobiological links with high intelligence	Brain biology Life events changing brain chemistry Affected by neurological factors
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The above vulnerability factors related to events that have happened in the past, events which were felt by respondents to have destabilised students and made them prone to emotional and mental health problems. Some past experiences e.g. a difficult relationship with a parent, may still be current stressors. For the sake of simplicity anything that occurred before starting at University or College has been classed as a ‘past experience’, whilst events and situations that had happened since becoming a student are described as ‘current stressors’. This is a somewhat arbitrary distinction and there may be some cases where a one-off event or episode which occurred while being a student would be better classed as a ‘previous experience’ leading to current vulnerability, as in the following instance:

I know of one particular student who is finding that she can’t cope. She was attacked in the street in Oxford, took four years out and has now come back... She gets over-stressed by all sorts of things and when something goes wrong she can’t sort it out.
Student representative OXU S04 217-221

By far the largest category of stressors cited by respondents comes within the category of social causes. These are situations and events experienced by students in the course of their academic and personal lives. Respondents were able to describe many aspects of students’ lifestyles which taken together have a negative impact on their well-being (Table 3.8 and Appendix 3.2).

At the University of Oxford there was a greater emphasis on the pressure, intensity and competitiveness of the social and academic environment.

A lot depends on the students’ background, but there is increasing pressure in the first year and then increasing stress towards the finals. Students think they can have a good time. But as Oxford has very short terms and the workload is intense and students have exams at the beginning of each term, some find it too overwhelming. And there are those who don’t fit in, who spend too much time on their own in their room not making friends.
College Staff Member OXU 019 90-95

⁹ Based on research interviews 2000-2003

Several respondents at Oxford Brookes University mentioned the impact of the scale and impersonality of the institution.

Some individuals manage very well, but the size and anonymity of the university affect others. With Freshers you can see the impact of the institution. There are some who were very good socially at school but come to the counselling service saying ‘I don’t understand why I can’t cope here’. Perhaps being away from home and the fact that they didn’t anticipate problems can make it shocking for them when they do have difficulties.

Counsellor OXB 008 60-65

Table 3.8 Social causes of students’ mental health problems: possible stressors¹⁰

Academic Work Critical tutorial feedback Disappointment with course quality Intense workload Exams Pressure from tutors Don't like their subject Problems with research work Competitiveness of the system Lack of academic support Lack of clinical supervision Distress from clinical placement Lacking structure Family Issues Parents splitting up Parent recently died Other bereavement Terminally ill parent New step-relations Pressures to succeed Poor relationship with parent Being away from their parents Leaving wife and children behind Experiencing a lack of emotional support Family responsibilities	External Pressures Worries about finances Having to take paid work Pressure to achieve in the job market Student Lifestyles Involved in too many activities Having no 'down-time' No time to think things through Poor emotional environment Not fitting in socially Experiencing relationship problems Experiencing accommodation problems Being cut off from ordinary life Experiencing isolation Making a major life transition Having unbalanced activities Affected by the stress experienced by other students Affected by the intensity of the environment Experiencing social fragmentation and rivalry Affected by uncertainty about the future Feeling the need to find a partner
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As in the case of identifying vulnerability factors, the division of stressors into social and psychological categories can be somewhat arbitrary. Events that are stressful for one student may not be so for another. The factors classed here as psychological are

¹⁰ Based on research interviews 2000-2003

those which seem to be connected with internal processes of thinking and feeling rather than with reactions to external events, but they can be closely linked.

It is difficult to distinguish whether it is that certain types of student find it difficult, or is it the course that is the source of the problem. Would they be going to counselling if they weren't at university? In most cases they would probably have ended up in counselling whether or not they were students, 75% certainly. Perhaps over half might have felt the need for support later i.e. it was coming to university that provided the trigger now.

Counsellor OXB 005 100-105

Table 3.9 Psychological causes of students' mental health problems: possible stressors¹¹

Comparing self to others	Experience of homesickness
Feeling concerned about being no longer the best in their group	Concern over sexuality
Feeling guilty when work goes wrong	Feelings of loneliness
	Re-stimulation of earlier distress

There were very few stressors mentioned by respondents which could be described as biological or physical in nature, the most often cited ones being illicit drug use and heavy drinking.

There seems to be an increase in the use of alcohol and drugs. This is either because there is more awareness and honesty about it or because usage is more prevalent. This is not so much the case with the more serious drugs, but cannabis use is common and not seen as a big deal by students. However, in the case of psychosis, I would be concerned about this usage.

Psychiatrist NHS 006 27-31

Table 3.10 Biological/medical causes of students' mental health problems: possible stressors¹²

Fatigue	Alcohol abuse
Physical illness	Illegal drug use

Particular issues of vulnerability and stress were identified in relation to certain groups of students, especially mature students, post-graduates and international students.

There are people for whom the decision to come back in education as a mature adults is part of bigger transition in their lives. Because of this, the experience, combined with the rest of what is going on, can be overwhelming.

Counsellor OXB 007 47-49

¹¹ Based on research interviews 2000-2003

¹² Based on research interviews 2000-2003

Mature students were seen as having to manage many competing demands in their lives. Those on undergraduate courses had less access to peer support in what was a predominantly youthful culture. Post-graduate students, especially those undertaking research, were felt to be at risk from isolation and anxiety. Students carrying out laboratory work were more likely to benefit from the support of colleagues and regular contact with supervisors than those in the arts and humanities.

According to the university counselling service, graduate students have as many problems as other students but they are more inclined to look after each other as they are more mature. However, they have less structured lives than undergraduates which could be a problem.

College Secretary OXU 021 15-17

International students in both universities were seen as a particularly vulnerable group. This was recognised at Brookes with the provision of specialist advice and support services, but not formally at the University of Oxford.

A lot of overseas students also have problems but they can't admit that they may be in the wrong place or needing help. They daren't return without a qualification. Overseas students are isolated and culturally displaced and find very little support within the university.

Administrator OXU 006 129-132

Any vulnerable students who entered the University of Oxford were seen as likely to find the high standards required of them quite challenging.

The institution affects students by being highly competitive, full of rivalry and soaked in elitism. It doesn't tolerate academic fools gladly.

Counsellor OXU 008 139-140

In contrast, a few respondents from the health services felt that Oxford Brookes University perhaps lowered its academic standards for entry too far in the case of certain students.

Brookes is very open but admits a number of people to courses who have no chance of completing.

General Practitioner NHS 004 142-143

3.6.3 The stigma of mental health problems

In both universities, although students could share experiences of feeling stressed and emotionally distressed with their peers, they feared disclosing problems which might be regarded as mental health issues to anyone. Students at the University of Oxford were particularly aware that it would not be easy to admit to having mental health problems within the prevailing culture of the institution.

The environment of the academic institution provides a negative influence and, as a result, students won't reveal they have a problem as they know what will happen. It is so difficult to convince people to seek help when they know what reaction they will get ... It is a mistake to show emotions, you are seen as dysfunctional, as weak. I am speaking from both personal experience and from the Welfare Officer role.

Student OXU S06 147-154

The same feelings were not expressed so strongly by students or staff at Oxford Brookes University. Stigma was still an issue, but in the opinion of one student with mental health problems was not insurmountable.

Mental health is still riddled with stigma. I find that people are normally so intrigued and they are really interested and as I am so open, and as I don't rock back and forth etc., they see you can be normal. And you may find that they have suffered something and it makes it easier to talk about things.

Student OXB S03 180-183

There were particular issues around disclosure of problems for students on healthcare courses.

Is there a particular stigma for Health Care students seeking counselling? In my view it changes. In my time it would have been a 'no-no' but gradually talking about feelings has become OK in the field. However, post Allitt etc., things may have gone back underground.

Counsellor OXB 009 192-195

Although respondents had concerns about the disclosure of mental health problems on the career prospects of students on vocational courses such as law, teaching, nursing and social work, some occupational therapy lecturers took a different view.

I have a role in the admissions team and have been asked to meet with students who have declared a mental health problem and have felt slightly uncomfortable about that. It was do with finding about their needs and to check their suitability, but why can't they be treated the same as other students? One was quite open about having bi-polar disorder and was very suitable for the course. Another had had an admission to hospital and the judgment was that they were not suitable. This was more about their professional suitability rather than their illness. It is about making a careful decision.

Lecturer OXB 022 9-15

Appendix 3.3 has further examples of the impact of stigma on disclosure and deciding whether to seek help.

3.6.4 Positive mental health factors and coping strategies

In addition to the factors which had a negative impact on the mental health of students, respondents indicated other factors which have a positive or protective effect (Appendix 3.5). These were felt to help protect the students against the stresses they encountered and to enhance their capacity to manage their thoughts and feelings appropriately.

Table 3.11 Positive and protective mental health factors¹³

Receiving emotional support from one’s family	Having someone to talk to
Having a well-functioning family	Possessing self-confidence
Getting emotional support from friends	Feeling connected to the educational institution
Belonging to a supportive group	Possessing religious faith

With many of the positive factors mentioned, there is a ‘chicken or egg’ situation i.e. which came first? There seemed to be a reinforcing effect at work. Those students who made a good start at university/college and experienced some of the factors listed in Table 3.11 were likely to develop more and stronger protective factors as they progressed, further boosting their mental well-being. The students arriving with some of the vulnerability factors listed in Tables 3.5-3.7 were also less likely to be confident and supported and could experience more difficulty in making positive relationships with their peers.

I also see, later on, those who haven’t made such supportive groups around them. You don’t tend hear about problems from those students who are socially integrated. They probably don’t have so many problems?

Tutor OXU 020 54-56

Students and their supporters mentioned coping strategies that had been found successful, at least for managing stress, and perhaps also for reducing the impact of severe mental health problems. Many of these were individual activities which either helped the individual to relax or to take stock of their situation. Given the pressures and fast pace of student life mentioned earlier, such activities were seen as a necessary counter-balance.

¹³ Based on research interviews 2000-2003

Table 3.12 Successful coping strategies¹⁴

Practicing Yoga Using meditation Having a massage Attending stress classes Allowing time for relaxation Avoiding tiredness	Focusing on one thing at a time Getting information on their problem from the internet Talking to others Acknowledging problems Going for walks Engaging in sports activities
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Examples were also given of coping strategies that were found to be, or were considered likely to be, unsuccessful (Appendix 3.5), a chief one being avoidance of the problem.

The basic one is to avoid the problem by not talking about it. Some also try excessive partying, excessive drinking or throwing themselves excessively into their academic work.

Some will avoid other people. They do not want to hear that it would help to talk. They prefer to be in denial and they do survive.

Student OXU S06 95-98

Table 3.13 Unsuccessful coping strategies¹⁵

Denying that the problem exists Avoiding any talk about personal problems Hoping the problem would go away by itself Avoiding people Limiting one's social life Throwing oneself into work Trying to resolve problems by intellect alone	Accessing too many sources of support at the same time Relying too heavily on friends Indulging in excessive partying Drinking excessively Using illegal drugs Taking St John's Wort
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Taking St John's Wort, which has been recognised as a herbal anti-depressant, is described as an unsuccessful strategy because it was mentioned by counsellors and GPs as something that students had tried without success before coming to see them. Other students may have found it helpful and not accessed other forms of support.

¹⁴ Based on research interviews 2000-2003

¹⁵ Based on research interviews 2000-2003

3.7 Views on seeking support

You get students that will trawl around all the potential sources of support, but some never declare their mental health problem.

College Nurse OXU 010 20-21

I personally kept my own stuff out of sight [within the college] as I knew there wouldn't be much support and there are very few who will accept you as you are rather than as a charity case.

Student OXU S06 174-175

Some students were described as unlikely to seek any support at all for their emotional or mental health problems. Others sought help from certain sources whilst avoiding others (Appendix 3.6). Within the University of Oxford there were many comments about the atmosphere discouraging help-seeking. At Brookes there was seen to be a particular problem with getting male students to acknowledge problems linked to a 'macho culture'. In both universities there were a number of identified reasons for students not seeking help.

Table 3.14 Factors affecting students willingness to seek help¹⁶

Lack of awareness or denial of the problem
Hope that the problem would go away by itself
Belief that nothing could be done or would help
Lack of understanding of the nature of support available
Belief that the problem was not severe enough to be taken seriously by others
Belief that they should be able to resolve the problems intellectually
Fear that others would get to know and would gossip
Fear of being seen as weak
Concern about attracting a psychiatric diagnosis and possibly ending up in a mental hospital
Fear that the problem/diagnosis would go on their records
Concern about the impact on future career prospects

Given the reluctance of students to seek help, especially from formal sources, fellow students and staff in the academic institutions were seen as playing an important role in promoting and enabling access to support.

I now ask if it was the student's idea to come for counselling. I have discovered that many more who come at the suggestion of tutors or friends than I had previously realized. A number say 'I can't keep saying this to friends or family'. Some student haven't got friends. Occasionally I get someone who has done the rounds of tutors, advice staff etc., but this rare.

Counsellor OXB 006 37-41

¹⁶ Based on research interviews 2000-2003

3.8 What sort of support to seek?

Students had many different potential sources of support available (Appendix 2 Diagram 1). The reasons for choosing one particular sources of support rather than another varied between individuals, but were influenced by some common factors.

Table 3.15 Factors affecting students’ choice of support¹⁷

Personal evaluation of the nature of the problem requiring support
Knowledge of the type of support that will be enacted
Beliefs about the effectiveness of the support interventions offered
Desire to approach someone known to the student, or to use someone more anonymous
Extent to which confidentiality can be ensured
Previous experiences of accessing support – self and others
Attitudes towards psychological or medical interventions
Realisation that other sources of support have been exhausted

Friends were used a lot, sometimes perhaps too much (see Chapter 4).
However, the students did express some reservations about using friends for support.

Other students’ stress acts as a stressor as there is a lack of support despite the provision of a counsellor. Students will lean on other students and some take it to excess. This is a stressor on the student as you are the person’s friend and are on a course that is about being supportive, and the environment and your attitude doesn’t encourage help-seeking outside.

Student OXB S02 15-19

Table 3.16 Reservations about using friends for support¹⁸

They may not offer appropriate advice – e.g. assuming that depression is the same as feeling ‘down’
You cannot be sure that what is said to them will remain confidential
It is difficult to admit to having problems to others who seem more competent
Students want to show their ‘good side’ to friends and may not want to ‘contaminate’ the relationship with their problems
There can be a lack of boundaries to the support demanded e.g. long phones calls in the early hours

One reason for seeking professional support from e.g. a counsellor or GP was when the student felt that they had overburdened their friends. Friends of students with problems were concerned about who to consult and were reluctant to pursue ‘official’ channels. Students also used their families for support but had certain issues that they didn’t want to take to them. Many students lived too far away from their families to get

¹⁷ Based on research interviews 2000-2003

¹⁸ Based on research interviews 2000-2003

regular support from them and had to turn to other sources. At the University of Oxford, peer supporters and welfare officers (students) were seen as a halfway house between support from friends and more formal support.

Mostly they will approach friends first, unless it is quite a confidential matter, then they might bypass friends. Perhaps due to a fear that information will leak out or that seeking help affects your friendships. Sometimes better to leave the friendships unaffected by a concern ... In some situations the good friend is too casual, welfare officers are official enough but avoids having to go to the doctors, a good role as a bridge.

Student Welfare Officer OXU S02 45-48, 58-59

Other positive comments about welfare officers included views that they were more confidential than friends, could be approached by the friends of a distressed student for advice and would have a first-hand understanding of relationship and academic problems.

Whilst such support was seen as usefully bridging the gap between friends and official sources of help, it was also viewed with suspicion.

I wish welfare officers would stop trying to be mini counsellors and stick to providing information. The problem is that those with problems are drawn to others with problems so become welfare officers. You can tell that the new welfare officers will become depressed a term later so I invite them to see me now rather than waiting until they come in with depression later.

General Practitioner NHS 002 80-85

Table 3.17¹⁹ Concerns about using welfare officers for support

Their lack of experience
Their lack of training
They may take on cases that are too severe
Confidentiality issues
Their motivation for undertaking the role. Are they compulsive helpers or CV improvers?
Belief that the role attracts students who have had their own problems

Students also used personal tutors and other academic staff for support (Chapter 4) but had concerns about doing so.

I am not sure if tutors would understand mental health as being separate from intelligence ... Even if mental health is acceptable, the tutor is the most stressful person you encounter so their attitudes and knowledge would have to change.

Student Welfare Representative OXU S03 183-187

¹⁹ Based on research interviews 2000-2003

Table 3.18 Concerns about using tutors for support²⁰

Is it OK to admit to not understanding things to them?
Will they understand contemporary students' problems?
Can they be trusted to keep information confidential?
They might be required to write a job or academic reference for the student
They are very busy
They have their own problems

Residential staff played a key role as students spent more of their time in halls of residence and colleges than they did in lectures and tutorials. These staff were frequently the first to pick up problems, but they often felt frustrated by the difficulties of accessing additional support for their students.

Those who are depressed are hard to pick up, those who are falling apart underneath but try to appear strong. They are probably the ones who need the help most. It is a case of trying to pick up someone who seems not right and finding out what is wrong. The depressed people are less willing to get help, whereas anxious people are more willing.

Hall of Residence Staff Member OXB 011 78-82

Although counselling services only saw about 3-6% of students in Oxford, they were seen as the most obvious commitment to student well-being by the educational institutions. However, many staff commented on the difficulty of persuading students to access this form of psychological support. Respondents held quite strong views about counselling services which revealed a number of assumptions, some of which acted as a deterrent.

Table 3.19 Assumptions made about counselling services by students and staff²¹

Practice is based on Freudian principles
Only a psychodynamic approach will be offered
Nothing worthwhile can be achieved in a few sessions
Counselling is a last resort for students with serious problems
Counselling takes the lid off the student's problems but may not make them better
Counselling is the first rung on the ladder to becoming a psychiatric patient
Counselling will have to do until proper therapy is available
Counsellors are cold and detached and so not as good to talk to as friends
Counsellors are unnecessarily secretive about their work with clients
Counsellors are linked to the academic institution and have to serve its interests
Counsellors should be on call to respond to psychiatric emergencies

²⁰ Based on research interviews 2000-2003

²¹ Based on research interviews 2000-2003

Students were generally wary of seeking help from the counselling services and, if they did use it, were not likely to advertise the fact:

There is a lot of stigma around the use of counselling services, even amongst those who advise others to use it! I doubt whether those who suggest it would go themselves. Within counselling services there is a perceived degree of formality and organisation which probably turns people away from it, or makes them fear mentioning it to anyone.
Student OXU S04 176-179

However, other people recommending counselling may make a significant difference to making it more acceptable:

It is quite common for clients to say ‘its the last resort’ or ‘I’ve tried everything else’. They have used the GP, college nurse, friends and they say ‘why don’t you try counselling?’
Counsellor OXB 007 37-40

It was not clear from the research what proportion of students approached General Practitioners for emotional and mental health problems, as no records of this nature were kept by the Oxford practices or by the Primary Care Trust. Respondents’ comments indicated mixed views on approaching GPs:

I personally would rather go through the medical than through the University's Counselling Service as I would be in a better space outside of the institution – if it is because of personal issues that you feel you need support, it feels easier to speak to someone external. For the student the lack of link encourages honesty.
Student OXB S02 174-177

If the student had gone to a GP she could have been prescribed antidepressants and she didn’t want this because of the associated stigma, the fear of it being a sign of weakness and worries about confidentiality issues.
Student OXU S06 73-75

Overall, GPs were seen as more confidential than any of the forms of support available within the universities and colleges. However, there were a number of factors which deterred students from approaching a doctor.

Table 3.20 Concerns about using GPs for support²²

Fear of being put on medication
Concern that consultation will result in mental illness being recorded on the student’s medical record
Perception that GP would not have enough time to really listen to the student
Concern that some would be opposed to psychological approaches (with the possible exception of Cognitive Behavioural Therapy)
Fear that GPs linked to colleges/universities might feed information back to those institutions

²² Based on research interviews 2000-2003

Within the University of Oxford, college nurses were available to students at designated times. The extent to which they were seen as accessible varied between colleges.

I think the college nurse deals mainly with medical issues. The person has changed and I am not aware of her having any mental health knowledge. I am not sure that a student with mental health issues would go straight to her but don't know this for certain, since people do know of her which is an advantage.

Student OXU S03 67-70

In one college, students wouldn't approach the nurse about a personal problem, so the students need to approach a doctor. In another college, the nurse goes too far the other way e.g. too mothering and smothering towards the students.

General Practitioner NHS 002 67-70

There were less comments about students' attitudes towards psychiatric support, apart from a fairly widespread fear and stigma associated with needing that level of intervention. Psychiatrists are associated with treatment for psychotic illness and this did lead students to fear being sent to them. One consultant mentioned the need for a better understanding of his profession:

There needs to be more of a view or understanding as to why the service is there e.g. if a student in college needs to be sectioned. It is very public and not everyone will appreciate why it is necessary. They think 'just because he was smoking a few joints' but they don't know the psychiatric problems that have preceded this incident and may see it as overly authoritarian.

Psychiatrist NHS 006 148-152

One GP felt that highly intelligent students might find support from Community Psychiatric Nurses difficult to accept:

There is a problem with the allocation of CPNs to students in that CPNs have a certain level of intelligence below that of students and the students can find that patronising e.g. how can the CPNs understand a student's maths problem? As a result students may find it hard to accept help from CPNs. For a student, a CPN is a waste of time unless the student is psychotic and needing depot injections.

General Practitioner NHS 002 186-190

3.9 Summary

The three main providers of further and higher education in Oxford provided very different social and organisational environments for a diverse range of students. Although students made up a significant proportion of the city's population, Oxford did not contain specialist medically-based mental health services for students. During the period of the research project there were significant changes in the local health economy

with the introduction of a new Primary Care Trust for the city. The Oxford Student Mental Health Network provided an opportunity for agencies and individuals supporting students in healthcare, educational and other settings to meet and exchange ideas. The contacts developed through the Network enabled this research project to be undertaken.

There was no comprehensive statistical information available on the incidence of mental health problems amongst students in Oxford. However, students and those providing social, psychological and medical support to them had encountered a wide range of emotional and mental health problems within the local student population. These problems were identified by the perceived presence of particular thoughts, feelings, behaviour and experiences. Most respondents distinguished between the experience of stress which was widespread and understandable, and mental ill-health which was seen as more complex. Recognition of possible mental health problems was not confined to trained counsellors and healthcare professionals. Fellow students, academic, residential and administrative staff were all aware of students with such problems.

It was difficult to identify any explicit conceptual models of mental health adopted within the organisations which supported, treated and educated students with mental health problems in Oxford. Similarly, individuals who provided medical, psychological or social support rarely expressed allegiance to one particular philosophical, sociological or scientific viewpoint. With the exception of counsellors, psychotherapists and psychologists, most did not articulate a conceptual approach to mental health. However, different approaches to mental health were implicit in the support which they offered.

When it came to consideration of the causes of mental ill-health many respondents cited a variety of factors to do with vulnerability, stress and coping. Many social factors and a lesser number of psychological and medical/biological factors were cited as causing vulnerability to mental health problems and acting as triggers on becoming a student. Certain groups (post-graduates, mature students and international students) were seen as having particular experiences and issues which could make them vulnerable. The nature and culture of the educational institutions themselves were considered to have an effect on students' well-being. Respondents were also able to identify personal factors which might lead to positive mental health. A number of coping strategies were used by students in distress. Some of these were seen as helpful, particularly if they involved directly addressing the problems or actively promoting

relaxation. Others, taking the form of denial and avoidance, were typically seen as unhelpful.

There was considerable stigma attached to having a mental health problem, one of a number of factors which deterred students from seeking help. Students were concerned about the effects of any diagnosis received on their future careers and were often reluctant to seek formal help for this reason. There were particular issues for students on healthcare, social work, teaching and other vocational courses, where a medical diagnosis might affect their ability to enter their chosen profession. The nature of any support sought (formal or informal, social, psychological or medical) was influenced by the attitudes and perceptions of fellow students and others around them.

Students were generally seen as being reluctant to seek formal support for mental health problems. Other students, residential and academic staff members could sometimes help distressed students to overcome their reluctance to approach counselling or medical services. Friends were relied on to a large extent, especially for emotional and stress-related problems. However, there were concerns that friends could become over-burdened, offer unhelpful advice and not maintain boundaries of confidentiality. Whatever source of support that was approached, there were seen to be both positive and negative implications of doing so. Students held some strong views on counselling services, often based on misperceptions, which reduced their willingness to make use of them. Medical services were seen as more confidential and separate from the student's college/university than other forms of support. There was a perception that psychiatric services were for people with psychotic conditions and this caused students to fear that medical referral would lead to them being identified as 'mad'.

Chapter 4 Findings: Provision of Support within Further and Higher Educational Institutions

This research project examined the support provided to students with mental and emotional health problems by education, healthcare and other institutions. The term ‘support’ is used in a broad sense to include any actions which assist students in recovering from or managing their problems. The support given was categorised as social, psychological or medical.

Most respondents took a holistic rather than a polarised view of the causes of emotional and mental health problems. Where they did differentiate between approaches it was at the point of deciding what type of support they, in their role, should offer to individual students. For example, a hall of residence warden might believe that a student was depressed because of a combination of family circumstances and academic pressures. The warden could choose to talk to the student about the academic stress, whilst recommending that the student approach the counselling service to work on the family issues.

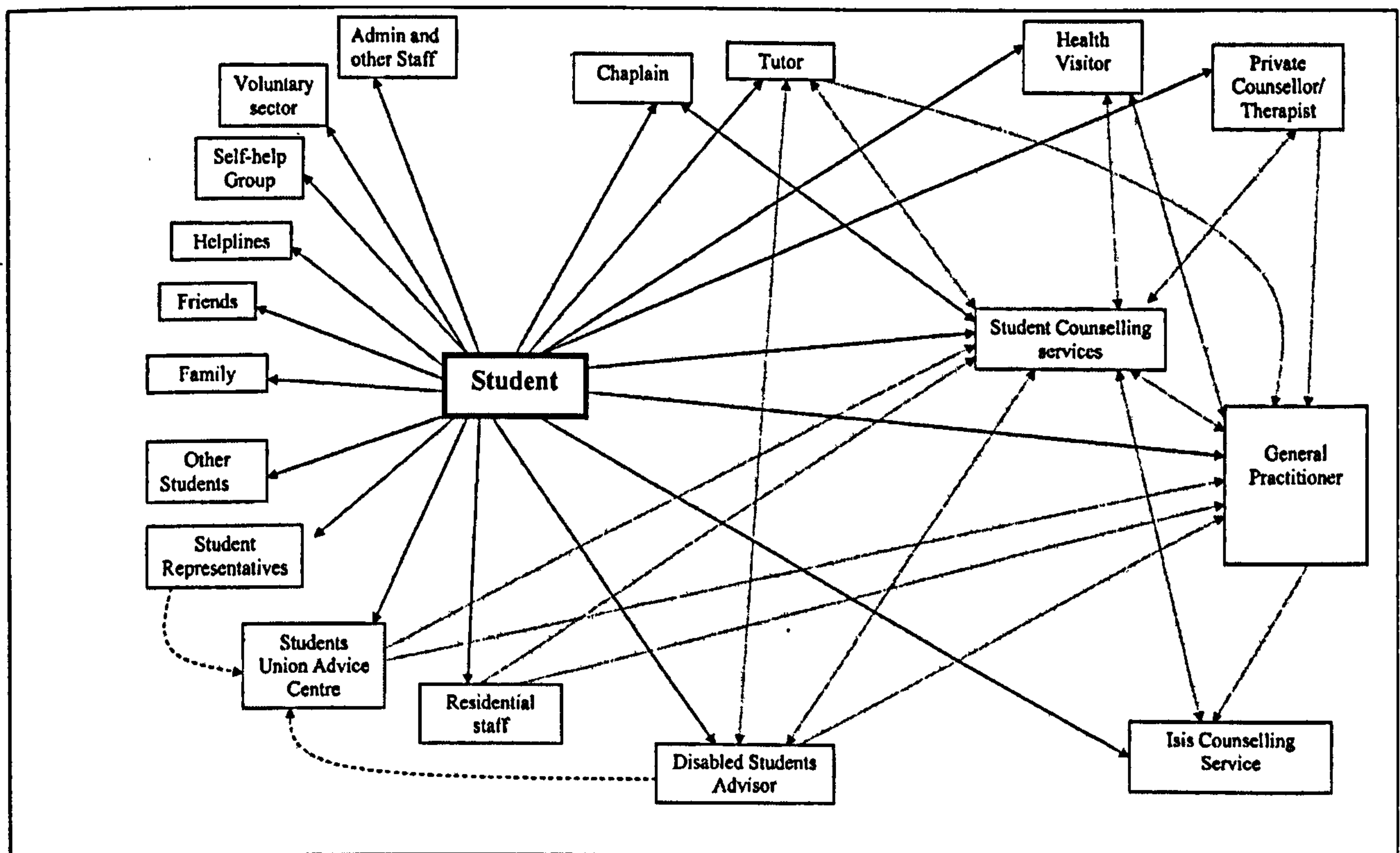
This chapter uses case studies of three educational institutions to examine some of the key issues faced by individuals when they were providing or receiving support. Individuals in the educational institutions operated within structures and services available to students who were emotionally distressed or otherwise experiencing difficulties. The university counselling services were just one part of a wider system of support offered to students in their universities. They saw between 3% and 6% of their institutions’ student population¹. There were broad similarities in the support structures provided by the two universities, but the system at the University of Oxford was much more decentralised and offered more formal mechanisms for peer support. In both cases provision was made for support at the social level (e.g. tutors and other staff), the psychological level (counsellors) and the medical level (doctors and nurses). The nature of this support is explored in this and the following chapter.

¹ Oxford Brookes University Counselling Service Annual Reports. University of Oxford Counselling Service Annual Reports.

4.1 Support within Oxford Brookes University

Students at Brookes used many different sources of support, many of them informal such as friends and family. Formal social support was provided by academic, residential and administrative staff, the Students' Union and specialist advisers working in Student Services. The Counselling Service, also based in Student Services, provided psychological support. The main medical support was provided by St Bartholomew's Medical Centre which also had facilities on Brookes' main campus and employed a Specialist Health Visitor for the student population. Students were also served by other medical practices near their campuses, halls of residence, or family homes.

Figure 4.1 Support available to students at Oxford Brookes University



4.1.1 Students providing support at Oxford Brookes University

In common with students at other universities, Brookes students provided much informal support to each other. In some cases students would approach their friends direct, in other case students were concerned about their friends and would approach others for advice on what they should do. Students at Brookes did not have the opportunity to become trained peer supporters, although some training was given to students who became Residential Assistants in Halls of Residence.

Some students found the experience of providing support to fellow students with emotional or mental health problems quite taxing (See Appendix 4.1.1). One student described how she was getting too many demands on her time and energy from a

particularly needy student, which made her reluctant to attend lectures. This situation acted as a trigger for her to draw a personal boundary and to suggest that the other person should seek professional help. Nevertheless, students were a major source of support.

Table 4.1 Examples of support offered by fellow students²

Listening to their problems
Offering advice
Providing reassurance
Showing empathy
Suggesting other sources of support
Getting advice from other people

Another student with personal experience of mental health problems identified a danger of fellow students offering advice:

Other people who have not experienced the full extent of a mental health problem can think that it is just like when they are feeling down, so they may not offer appropriate support or advice.

Student OXB S03 50-52

4.1.2 Support from academic staff at Oxford Brookes University

Although students were allocated personal tutors at Oxford Brookes, many respondents commented that there was not usually a close relationship between students and tutors. However, tutors and other lecturers would sometimes be approached by students with emotional and mental health problems, or might become aware of them by direct contact or through concerns raised by fellow students or residential staff. The university issued staff with information on how to assess students’ problems and what sources of support were available in the *Supporting Students Handbook*. Notwithstanding this access to information, tutors were very busy and had a large number of students allocated to them, which made it difficult for them to be proactive on welfare issues.

The support provided by tutors was described as ‘patchy’. Students could not always get timely access to their tutors and some tutors were not comfortable in dealing with emotional issues. Tutorial staff themselves realised this and recognised that students with problems would gravitate to certain members of staff who were perceived to be helpful or sympathetic. This was confirmed by comments from students

² Based on research interviews 2000-2003

themselves and from counselling and advisory staff, who encountered many different tutors (see Appendix 4.1.2).

The best relationships seemed to exist when students knew how to make appropriate use of what their tutors were able to offer. Tutors were most comfortable with focusing on the academic impact of a student’s problems rather than getting involved with ‘counselling’ the student. However, those interviewed felt that it was important to listen to their students’ problems. In some cases it was enough for them to have been heard, in others the students were considered to need further support from a counsellor or a GP.

If I referred a student to counselling, I would treat it as a additional resource. I would keep in touch with the student and let them know that they can come in and have a cup of coffee and a chat, a chance to let their hair down. I see students with problems with motivation and worries about their work, but this is typical of some young students.

Tutor OXB 020 28-32

Table 4.2 Examples of support offered by academic staff³

Listening to the student’s problems
Offering tea/coffee and a chat
Referring the student to the Counselling Service, advice services or their General Practitioner
Liaising with other sections of the university and placement providers
Offering support over academic issues
Providing reassurance
Encouraging the use of problem-solving skills
Helping the student to access hardship funds
Maintaining contact with the student, in person, by phone and by e-mail
Extending essay deadlines
Setting up separate rooms for taking exams
Encouraging the development of friendship groups

One tutor with personal experience of managing a major mental health problem distinguished between those students who were depressed or anxious in response to situational factors, and those who had a family history of mental health problems with a possible genetic basis. The former would be supported by the tutor alone or referred to counselling, the latter would be advised to see a GP for medication. A similar approach was taken by some staff teaching on healthcare courses. There was a striking difference between two tutors on the same course. One was picking up around 15 students a year

³ Based on research interviews 2000-2003

with emotional or mental health problems and referring them on to counselling or medical services, whilst another was only aware of one or two students with problems and had not referred any on.

The tutors interviewed were willing to provide support that helped the students with the academic side of their work, and were often willing to lend a sympathetic ear to students who had problems such as debt, bereavement or relationship troubles. The decision to refer the student to others was influenced by whether the problems were long-term and ongoing, the severity of the problems, the risk of suicide or self-harm, and the perceived need for a medical or psychological intervention (see Appendix 4.1.2). Staff on health care courses were particularly aware of the need to maintain a relationship based on the student's academic needs and not to be drawn into a therapeutic relationship.

4.1.3 Support from residential staff at Oxford Brookes University

Oxford Brookes University has eleven Halls of Residence, spread across several different locations on the east side of Oxford, as well as at Wheatley and Harcourt Hill both of which are a few miles out of the city. Residential staff provided the first-line support to students who are mostly first years. With 2,500 students in residence (due to expand to 3,500 in September 2003), a smaller proportion of the student population were in contact with residential staff than at the University of Oxford. However, these staff were aware of a wide range of student problems.

Hall Managers were normally on duty during the day, whilst Hall Wardens and Residential Assistants (students) were on site during the evenings and weekends and often became aware of students in distress at these times, either through direct contact or observation, or by being alerted by other students. Residential staff commonly identified three types of problems amongst their students.

- Students who displayed disturbed or disturbing behaviours
- Students who seemed very needy and sought the attention of staff
- Students who were withdrawn and isolated

Residential staff had some basic training in listening skills and identifying sources of support, but many felt that they needed more. Staff often had concerns about their ability to manage the situations they faced, but they also had a lot of insight into the factors that affected students. It was not only training that they were concerned

about, but also issues of safety and lack of information about individual students. Staff dealt with challenging situations such as self-harm, attempted suicide and psychotic episodes, often at night or at weekends when other sources of support within the university were unavailable.

The staff members felt that they had no choice but to intervene at the point of a crisis. Some also took on a proactive role, seeking out distressed students and attempting to build a social community within their Halls. Other felt busy enough dealing with the problems that were presented to them. All Halls, despite differences in size, were staffed at the same level, giving rise to very different staff/student ratios.

Having become involved, the decision about continuing to support the student within the Hall or to refer them on was influenced by the nature of the situation. Staff were more likely to offer support if the student’s distress was seen as logical, e.g. a reaction to a relationship break-up or a bereavement. They were mostly likely to involve the Counselling Service, medical services or in extreme situations the police if the student’s behaviour was interpreted as difficult or bizarre, if the level of distress was severe, if the student’s distress was ongoing, if there was self-harm or a threat of suicide, or if there was a perceived risk to others. Staff were also most likely to refer on if they were feeling the pressure of other work demands. They also recognised the limitations of their knowledge and skills in dealing with mental health problems.

Table 4.3 Examples of support provided by residential staff⁴

Listening to the student’s problems
Asking the student to write down their concerns
Trying to get to the root of the problem
Offering advice or putting the problem into perspective
Supporting other students who are supporting the student with mental health problems
Helping the student move to more suitable accommodation
Providing the student with reassurance
Showing concern for the student
Using humour to defuse a situation
Providing information on other sources of support
Arranging for the student to talk to their tutor
Encouraging the take-up of counselling or medical support

⁴ Based on research interviews 2000-2003

Attempts to refer on did not always work, either due to the student not wanting to take up the help, or because of waiting lists and other access issues. Referral did not necessarily put an end to the problems experienced within the Hall.

I will tell someone to go to an adviser or counsellor, but things don't always change and then the situation falls down, and you don't know what to do with them.

Hall of Residence Staff Member OXB 011 93-94

It was frequently frustrating for residential staff that counsellors, advisers and medical staff could not share background information with them on students who displayed disturbing behaviour. They felt that there was a one-way flow of information from them to the professionals, and that they were disadvantaged by not knowing what to expect of the student or how to treat them (see Appendix 4.1.3).

Some residential staff referred to the difficulty of balancing a role that included both discipline and welfare and expressed the opinion that it was becoming more difficult to maintain the welfare side of their work (see Appendix 4.1.3). Some staff were concerned about the direction that the Halls were going in. New and refurbished Halls were being privately financed and run, cutting the connection with university staff.

4.1.4 Support from advice services at Oxford Brookes University

Perhaps in recognition that pastoral support through tutors was not as strong at Oxford Brookes as at other older universities, the university's Student Services department provided a broad range of advice and counselling services as shown in Figure 4.1 earlier in this chapter. The Students' Union also ran an Advice Centre. The advice services were distinguished from counselling services by their focus on providing information rather than on developing insight or dealing with emotions. As the advisory and counselling services at Brookes shared a receptionist in common, students could approach Student Services unclear as to whether they required advice or counselling.

There were advisers for international students and mature students, both of whom encountered students with mental health problems. As both of these advisers also worked as part-time counsellors within the university, they were sometimes faced with a situation where an advice session was heading in the direction of becoming a counselling session.

If I saw the student in an advice capacity and felt that counselling was necessary, I would either provide counselling and refer the student to someone else for advice or would offer the advice and refer the student elsewhere for counselling.

Adviser OXB 002 19-22

The Brookes Disability Advice Service supported students with mental health problems, sometimes because a mental health problem was the presenting disabling condition. In other cases a mental health problem was experienced alongside another disabling condition. The Disability Service was approached by students with mental health problems in advance of them starting at the university, at the time of joining the university and by students who either developed problems or decided to declare them at a later stage in their studies. In some cases the service was approached by the student's parents, in these cases they asked the student themselves to make direct contact. The students who used this service tended to have more severe mental health problems such as schizophrenia, bi-polar disorders, clinical depression and anxiety disorders. The support offered was not therapeutic in nature, but concentrated on the practical adjustments that could be made to enable the student to study successfully at the university. The Service also offered the student a point of contact, a place to 'check in'. Examples of the types of support provided are given in Table 4.4.

Table 4.4 Examples of support provided by the Disability Service⁵

Explaining to the student what they might encounter at the university and what support would be available to them
Making contact with tutors to explain the student's situation to them
Making contact with tutors to negotiate extensions to assessment deadlines
Supporting the student in finding suitable accommodation
Obtaining funding from the Disabled Students Allowance for a personal computer
Obtaining funding from the Disabled Students Allowance for a note-taker to attend early morning lectures on the student's behalf
Helping the student to identify a pattern of study that would work for them

Where a student had therapeutic needs, the advisor was willing to help them access counselling or medical services. Similarly, such services would refer some of their clients to the Disability Service in order to help them deal with the practicalities of academic life.

The Students Union Advice Centre saw a number of students with mental health problems. A number of students who came for advice because they had got into

⁵ Based on research interviews 2000-2003

difficulties with debt, with their accommodation, with the police or had got seriously behind in their academic work were judged to have underlying mental health problems. The Students' Union served as a place to drop in for students who were feeling isolated. Advice Centre staff reported being approached by students who had paranoid feelings that the university was against them. Such students were experienced as demanding and time-consuming by staff, but they did their best to help them.

Table 4.5 Examples of support offered by the Students Union Advice Centre⁶

Listening to the student's problems
Reflecting what they have said back to them
Offering practical advice e.g. on managing debt
Helping them to understand the university structures
Suggesting other sources of support

4.1.5 Support from Counselling Services at Oxford Brookes University

The majority of counsellors were based at the central Student Services building at Headington Hill Campus, with part-time counsellors at the Harcourt Hill site and the School of Nursing. There was no counsellor at the Wheatley Campus. One full-time and seven part-time counsellors were employed, all of whom were interviewed. Five described their approach as psychodynamic, one of whom occasionally also used cognitive approaches, and another also used some integrative work. Of the remaining three, two described themselves as integrative (psychodynamic plus person-centred approaches), and one used a solution-focused approach.

The Counselling Service had back-up from a part-time psychiatric consultant. This enabled counsellors to get a second opinion on students who seemed to have severe or enduring mental health problems. The counsellors saw around 500 students annually⁷, which represented about 3% of the number of students registered at Brookes. Just under 60% of those students attended for between 1 and 3 sessions. Ten percent were seen for 8-15 sessions, and a further 3% had 16 or more sessions. Counsellors did not see the focus on short-term therapy as a problem for the general range of emotionally distressed students. They were clear that their main task was to help the person engage with their life as a student. Some were frustrated that there were other

⁶ Based on research interviews 2000-2003
⁷ OBU Counselling Service Annual Reports

students with deeper therapeutic needs whom they could have helped if they were able to offer more time (see Appendix 4.1.4). There was a large workload for the counselling staff and at busy times a student might have to wait two weeks for an appointment. These waiting times, although not long compared to NHS provision, may have put some students off attending.

There can be a need to get access to someone fairly immediately. A two week wait for counselling is not great as people wait until they are desperate before approaching a service, so it is not great to have to wait at that point... The danger is you have to struggle through the two weeks or say to yourself 'it's obviously not that bad or they would have given me an appointment before now'.

Student OXB S03 102-107

Of all the groups interviewed, counsellors were the most reflective and detailed in their responses concerning the support they offered. One factor in this may be the regular supervision sessions they attend, which give them the chance to reflect on and analyse their practice in detail. Another is that, in comparison to the supporters at a social level, counsellors have had intensive training in helping skills and put them into practice on a daily basis. Table 4.6 shows their responses to the question about what type of support they offered.

Table 4.6 Examples of support provided by counsellors⁸

Hearing the students' problems
Identifying whether the problems arise from the students' situation or from individual pathology
Assessing the students' needs
Establishing a good working relationship with the student
Supporting the transition to university life
Offering the students space to explore their situation
Helping students to clarify and process their problems
Helping students to express their feelings and move on
Helping students make connections between present and past experiences
Helping the student to identify repeating patterns in their life
Helping the students to reframe their feelings
Helping students to think about their options
Giving students 'homework' to do on their feelings and thoughts
Helping students to link their thoughts and behaviour
Getting students to think about the impact of their drug and alcohol usage
Reflecting statements back
Supporting students in gaining insights
Helping the students to learn from their interactions with the counsellor (working with transference

⁸ Based on research interviews 2000-2003

and counter-transference)

Demonstrating their belief in the students' abilities

Normalising the students' experiences

Supporting developmental tasks of separation from parents

Referring students to other services

These responses reflect the range of approaches used, including person-centred, psychodynamic and cognitive behavioural. They differ from those of the social supporters, not only in the absence of advice-giving activities, but also in the depth of exploration of the person's issues and in the practical application of theory to the situation.

The counsellors interviewed felt that it was always appropriate to meet those who presented themselves to the service for an initial assessment session. After this both parties would make a decision as to whether further sessions would be useful. Counsellors also had to make fairly rapid decisions about whether to refer the student on for medical or longer-term psychotherapeutic work. In the latter case this would normally involve the student finding a private practitioner, as access to NHS psychotherapy could only be through their GP. Thirty-three percent of students using the Brookes Counselling Service only attended for one session.⁹ Common reasons cited by counsellors for students not being engaged in further sessions included:

- Students whose needs were met during the session
- Students who needed practical advice services e.g. on managing debt
- Students who did not feel counselling was appropriate for them
- Students who needed immediate referral to medical services.

The decision to refer a student on to medical services was influenced by the counsellor's perception that the student had serious mental health problems. Some clients were described as 'borderline' and counsellors were not comfortable working with them without an additional assessment from the Service's psychiatric consultant or another medical professional. Referral between services is addressed in the next chapter.

⁹ Oxford Brookes University Counselling Service Reports

For each student who was taken on for counselling beyond the initial assessment session, counsellors who used more than one approach had decisions to make about which to offer.

My supervisor is psychodynamically oriented but sometimes suggests that I take a cognitive approach. You have to decide fairly quickly which approach to use, certainly within at least two sessions, otherwise you will be in a muddle.

Counsellor OXB 006 61-63

The choice of approach (Appendix 4.1.4) was influenced by a number of factors including:

- The counsellor's experience of different approaches and their attitudes towards them
- The nature of the student's problem, e.g. a behavioural approach to drug or alcohol abuse, but a psychodynamic approach to separation issues
- The nature of the individual student and their ability to work with a particular approach, e.g. a cognitive approach for those who are not comfortable with emotional issues
- Timing issues, e.g. the need for a quick solution-focused response so that the student can get back to their studies.

Counsellors identified particular challenges when working in an academic context. A key difference compared to other contexts, e.g. private practice, was that the majority of the work was short-term, averaging between two and four sessions per client. Other differences included:

- The counsellors were employed by the university and not hired by the client
- A number of students would leave Oxford for the vacations, thus breaking the flow of the work
- The main focus was on helping the students cope with their academic life rather than providing a more general therapy for life problems
- Some students were under pressure to attend because they faced disciplinary proceedings
- Counsellors needed to understand university life and the policies and structures of the institution.

Although they were employed within the university, counsellors did not always feel that their voice was heard within the wider organisation. Some of the counsellors interviewed would have welcomed the opportunity to feed ideas and general information back to other staff in the university, using the insights they had gained from working with distressed students.

Staff health and stress has a big impact on students. Their stress can be taken out on students. Therefore the institution cannot afford to ignore staff needs. There is a need for an induction and an ongoing induction process on well-being and this needs to be sold to the students and staff as a means to better working. Much emotional distress arises from the fact that the emotional environment is not conducive to mental well-being and there is not enough information or chances to think things through and this needs looking at.

Counsellor OXB 002 188-194

4.1.6 Support from medical services at Oxford Brookes University

A large number (roughly 8,000) Brookes students were served by one main Medical Centre which had a branch on the main campus. Students were also served by other medical practices near to the other two campuses, Halls of Residence or their homes. With the change from GP fund-holding to Primary Care Group/Trust financing of primary care, the Medical Centre lost its former specialist provision of psychological therapies for students. This was felt to be a backward step by many who had seen the benefits of that service and now saw students waiting for up to a year for equivalent NHS services.

Brookes was unusual in having a Health Visitor (employed by the Primary Care Trust through the Health Centre) based on campus for the student population. This person was able to promote healthy lifestyles and offer stress management sessions to students in groups and individually. She also acted as a pathway to other sources of care. Although this was a medically-based service, the support offered was based on a holistic approach as indicated on the Health Visitor's web-page:

Health is influenced by so many different factors and embraces mental, physical, emotional, spiritual and social well-being and the aim is to help students make informed health choices not only this term and next term but long term.

Individual support and advice is also available on a whole range of health matters from stress management and eating problems to help and advice on how to stop smoking. As the University Health Visitor I offer a starting place to talk things through informally.

(<http://www.brookes.ac.uk/student/services/health/> accessed 05.08.03)

Further details of the nature of the medical support offered to students at Oxford Brookes and other local institutions can be found in Chapter 6.

4.1.7 Satisfaction with support at Oxford Brookes University

Some respondents including one student and two counsellors (see Appendix 4.1.5) described Oxford Brookes University as being large and impersonal. This was contrasted with the collegiate experience at the University of Oxford where students were known and had a sense of belonging. The modular degree system and the limited opportunities for students to live in halls of residence made for a more fragmented existence compared to studying at the older university. The size and relative anonymity of Brookes made the provision of formal support services an important feature. Tutorial and residential staff often had dealings with vulnerable students, but did not always feel sufficiently trained or supported. Residential staff were given some basic training in dealing with students' problems, but felt that the issues raised by mental health problems needed greater input. These staff also had a heavy workload which limited their ability to offer support. The staff/student ratio at Brookes was such that staff were dealing with over twice as many students compared to those at the University of Oxford (Chapter 3 Table 3.1).

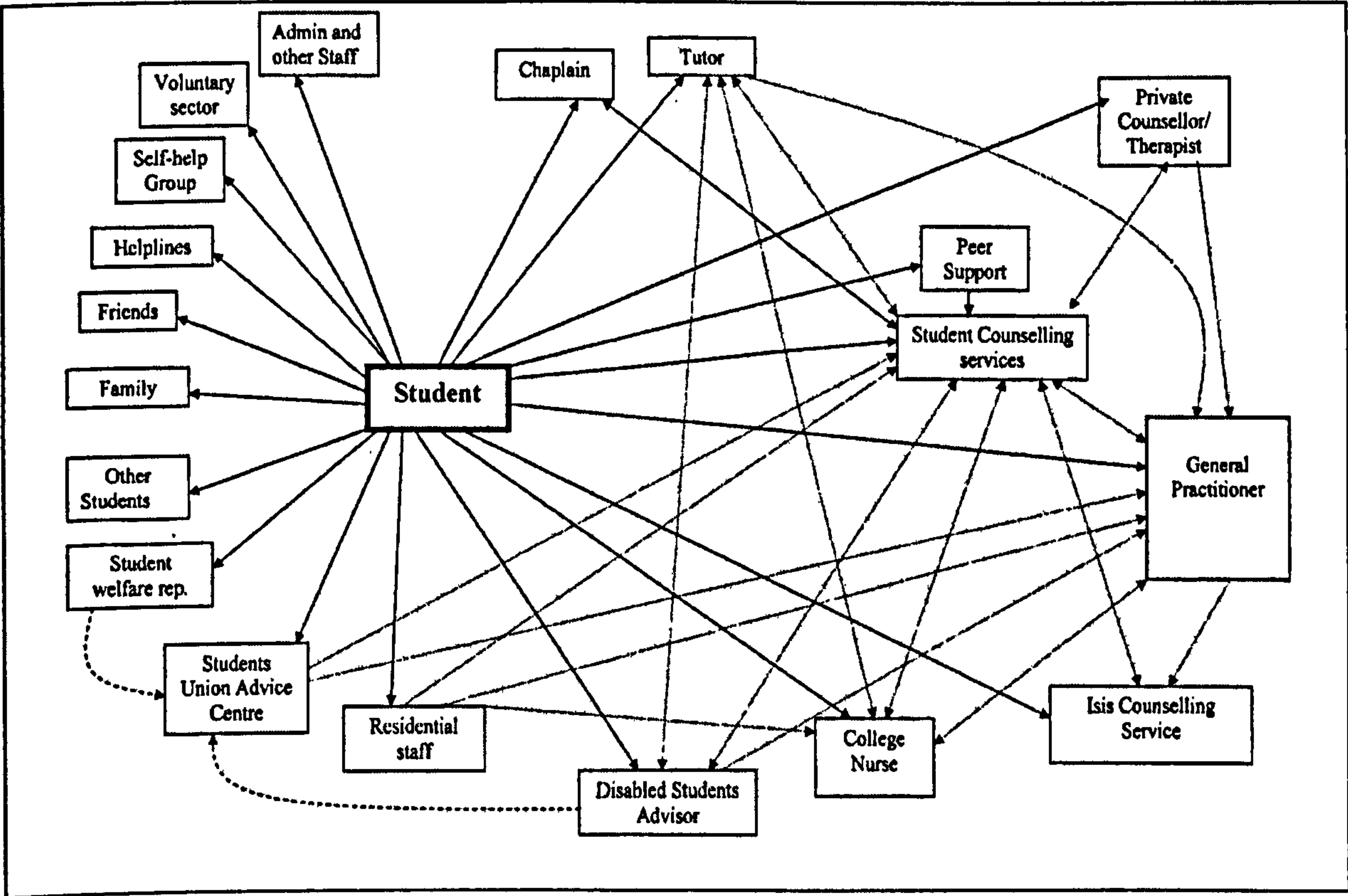
Student Services' support for students experiencing the whole range of emotional and mental health problems was valued within and outside of the university. Some university staff seemed to expect more from counsellors than their role or resources permitted. Notwithstanding resource constraints, counsellors were able to support some students who experienced serious mental health problems. The disability advisers provided support for students with mental health problems and advised on reasonable adjustments. They also provided a point of contact for vulnerable students and those who supported them. There were many responses from staff in mental health services and different sections of Brookes University acknowledging the role that the Head of Student Services played in resolving some difficult situations involving students with serious mental health problems. Being able to identify a senior person responsible for such issues was reassuring to others who were trying to deal with complex situations involving different departments across the health and education sectors.

4.2 Support within Oxford University

The Oxford University colleges played a key role in the lives of students (especially undergraduates), providing both accommodation, social activities and tutorial support. Some colleges were able to offer undergraduates accommodation for the whole of their three years, whilst others aimed to provide accommodation in at least

the students' first and third years of study. There was much informal social support available within the colleges, which was backed up by more formal systems of pastoral care. Beyond the colleges, the Students' Union Advice Centre and the Disability Officers provided additional social support. A central Counselling Service provided psychological support. Primary level medical support came from Nurses and GPs linked to particular colleges. The network of support available is illustrated in Figure 4.2.

Figure 4.2 Support available to students at the University of Oxford



4.2.1 Students providing support at Oxford University

The provision of informal social support within the student population was widespread. Whilst students viewed this as a regular part of student life, certain students were sought out more than others and found that the demands made upon them could be quite high (see Appendix 4.2.1). The demands were not only the amount of time taken up, but also the fact that support could be requested late at night and go on into the early hours.

Table 4.7 Support offered by fellow students at Oxford University

Listening to problems
Seeking advice from others
Socialising together
Suggesting support from counsellors, GPs and others

In addition to this informal support, Oxford University had student-based welfare systems in place, which were much more developed than those at Oxford Brookes University.

4.2.1.a Peer Support

Just over half the Oxford Colleges had opted in to the Peer Support Scheme, which trained students to provide immediate support to their peers and to facilitate their access to other services such as counselling. Each college had to pay for a panel of four of their students to be trained and supervised during the academic year.

The thirty-hour training consists of ten three-hour sessions designed to enable people to be more effective with peers. Skills learned through the training include being a good listener, helping others to feel more comfortable with social, academic and personal relationships, helping others to make decisions without giving advice, and managing and communicating about sensitive issues. An emphasis is placed on the listener learning his or her limits within a listening situation, and when best to refer on the person to whom they are giving support.

Information Sheet from University of Oxford Counselling Service 2001 *Peer Support Training Programme*

The Peer Support scheme had to counter concerns that, whilst developing counselling skills in their trainees, they were not encouraging students to become ‘amateur counsellors’. Their emphasis was on ensuring that students offered appropriate support and encouraging referral to services when appropriate (See Appendix 4.2.2).

Some respondents expressed concerns about the Peer Support Scheme:

- Did the supporters have enough practical training for the work they were doing?
- Were they motivated by trying to meet their own emotional needs?
- Would they get out of their depth with some of the situations they encountered?

The Peer Support trainer and other members of the counselling team felt that these concerns were met by the intensive initial training, and the provision of ongoing support and supervision. Although some respondents were sceptical about the value of Peer Support, it was seen by others to be a positive addition to the network of support available (See Appendix 4.2.2). An external review of the Peer Support scheme recognised its part in the provision of support and welfare within the university.¹⁰

¹⁰ *Peer Support Training Programme* <http://www.admin.ox.ac.uk/shw/peers.shtml> accessed 19.08.03

4.2.1.b *Welfare Officers*

Most colleges had Welfare Officers who were elected for a year (usually during their second year of study for undergraduates). They were an identified point of contact and kept an eye open for students in distress. Welfare Officers were seen as enabling students to seek support when they might be reluctant to use other sources of help (see Appendix 4.2.3). The Welfare Officers interviewed believed that they were seen as more confidential than friends and could be approached by students who didn't want to use the Counselling Service. The Officers sat on relevant college committees raising welfare issues.

Some respondents were concerned about those who took on the role of Welfare Officer. Once elected, they had very little preparation or training other than voluntary sessions organised by the Students' Union. One GP raised a concern about the post attracting students who had experienced distress themselves (see Chapter 3, section 3.8). One Welfare Officer, who had been treated for depression, offered another point of view; that personal experience could be advantageous in the post.

I do not see this as a problem. Most people have been through problems – many counsellors and GPs have been through problems which might have influenced their career choices. If you are aware of this you can separate these things. Additionally, you have your own support systems and know where to go for that support. You wouldn't do it if you didn't feel secure about what you were doing.

Student Welfare Representative OXU S06 84-88

Peer Supporters and Welfare Officers offered a level of social support that acted as a bridge between the everyday informal support enacted between fellow students, and the more formal avenues of support available from tutors, counsellors, GPs and others. In some cases they were approached by the student directly. Often they were approached by friends of a distressed student and occasionally they would approach a student who seemed distressed or isolated. One Officer had tried advertising 'surgery hours' when he would be in his room, but found that students preferred to make informal contacts at other times, or to use e-mail. Examples of the types of support given by these students are given in Table 4.8 below.

Table 4.8 Examples of support offered by Peer Supporters and Welfare Officers¹¹

Providing leaflets on self-help and other sources of support
Listening to students' problems
Talking with the student as a quasi-friend
Showing an understanding of relationship and academic problems
Providing reassurance to a distressed student or their friends
Getting advice for the student from the college nurse
Encouraging the student to seek professional help if necessary
Explaining the nature of counselling and attempting to de-stigmatise the use of services
Maintaining regular contact with students who are using counselling and other services
Advocating on behalf of the student to academic staff
Offering advice to the friends of a distressed student
Helping students to fill in forms for financial aid
Organizing social events
Encouraging isolated students to participate in activities

This support was offered by those who lived and worked in the same community as those they were supporting. This was a very different situation to going to a counsellor or GP who were unlikely to be encountered by the student at other times. The student supporters interviewed were aware that they had to be seen to maintain confidentiality and that the student would not want others to be aware that they were seeking support.

Whilst no problem was seen as too trivial to be addressed at this level, at the other end of the spectrum of need, the supporters sometimes had to decide if they should recommend the use of counselling, medical or other external sources of help. The factors that would trigger this included:

- The severity of the student's problems
- The supporter knowing that they had reached their limits
- The support given not seeming to be making any difference
- Concerns about suicidal thoughts.

¹¹ Based on research interviews 2000-2003

4.2.1.c Nightline

For students who wanted to remain anonymous the ability to ring someone up in confidence was extremely valuable. Nightline is an entirely student-run help-line and drop-in service which offers support to students in both universities between the hours of 8.00 p.m. and 8.00 a.m. during term-time. Student supporters found Nightline a useful back-up for distressed students who did not want to approach counselling services. The service received 250-300 calls per term¹²; of these 3 on average would be about suicide and many were to do with stress and depression. There were also occasional calls from students with schizophrenia or bi-polar disorder who did not want to approach formal sources of support, due to fears about confidentiality and disclosure.

4.2.2 Support from academic staff at Oxford University

Many tutors had regular and close contact with their students but not all tutors wanted or had the skills to become involved in non-academic matters. They became involved either because the student had approached them for help, because other staff or students had alerted them, or because they had noticed something about the student that had concerned them e.g. a decline in their work performance. Those tutors who could offer appropriate support were appreciated by students, counsellors and healthcare staff (see Appendix 4.2.4). The close nature of college life meant that staff were often very aware of vulnerable students. Some colleges had a pastoral or welfare committee and openly discussed students whose problems had been noticed. Whilst the tutors and college staff found this to be very useful, it raised problems for college nurses, college doctors and counsellors who were governed by professional codes of confidentiality.

Table 4.9 Examples of support given by academic staff at the University of Oxford¹³

Listening to the student's problems
Giving the student advice
Trying to help the student get their problems in proportion
Helping the student to tackle academic difficulties
Advising students on surviving the examination period
Informing students of the pastoral care available
Keeping an eye on vulnerable students
Checking the situation out with other college staff
Asking other staff to watch out for the student

¹² Oxford Student Mental Health Network: Notes from meeting with Nightline Co-ordinator 07.11.01

¹³ Based on research interviews 2000-2003

Maintaining regular contact with students

Alerting the college nurse and college doctors to serious conditions such as eating disorders or depression

Trying to persuade students to seek help from counsellors, GPs or college chaplain

Tutors were most likely to offer support if they felt the problems were ones they could cope with, or if the student needed academic advice. Tutors were likely to refer the student on if there were was no apparent reason for their distress, if the problems were seen as being beyond their capacity, or if there was a fear of injury to self or others. One tutor mentioned the occasional difficulties in mixing pastoral care with other duties.

A simple example is of an undergraduate female student who had problems with her credit card bill and I was both a pastoral advisor and tutor to her. As her tutor, I would be writing references for her, but as the student wanted to work in a merchant bank she didn't want me to know her problem. This was a pity as I could have helped, but the student was too afraid that she would get a poor reference in relation to financial matters.

Tutor OXU 023 206-211

4.2.3 Support from residential staff at Oxford University

Colleges at Oxford University are very different institutions to the Halls of Residence at Oxford Brookes University. For undergraduates in particular their life revolved around their college. The students' tutors were normally based within their college, as were administrators, librarians, chaplains, domestic and other college staff. These non-academic staff often became involved with distressed students, sometimes because of their role and sometimes because of their personal qualities.

I am one of life's chatterers and students come to me and it becomes apparent that it is more than trivial chat. They are trying to raise something much closer to them, which they may not be able to identify. Also there are the obvious ones 'I am pregnant'. I never give advice. Through talking they may find their own way, if not I will offer some possible answers.

College Staff Member OXU 015 46-50

Examples of the types of support offered by college staff (not including those who had academic positions) are given in Table 4.10 below.

Table 4.10 Examples of support offered by non-academic college staff at Oxford University¹⁴

Letting the student talk about their problems
Offering some possible options
Providing practical advice
Encouraging the student to take part in activities
Showing warmth and empathy
Enabling a depressed student to stay on at college during the vacations to avoid a difficult home situation
Providing an ‘ordinary’ relationship (like talking to an aunt or a neighbour)
Expressing concern and alerting students to the existence of counselling and other services e.g. in the case of anorexic students who were getting thinner

College staff were likely to suggest counselling, medical or other services to a student if he or she was not getting better despite the social support given to them (see Appendix 4.2.5) Other factors giving rise to referral were: fear of suicide, bizarre behaviour, aggression or other signs of mental disturbance.

4.2.4 Support from advice services at Oxford University

Advisory services were much less developed at Oxford University compared to Oxford Brookes University. The Students’ Union employed a part-time advice worker. This person was approached by students directly or through college Welfare Officers, but rarely had students been referred by university or college staff members.

The OUSU Student Advice Service is a confidential listening and advice service and aims to provide a space for student to talk over their worries in confidence, and to offer advice on a range of issues which students might encounter during their time at Oxford. Members of the service can provide you with both practical advice, for example about leasing a house, as well as with support for personal issues. The advisers are all experienced in dealing with students and can help you work through your problem in a supportive environment.
<http://www.ousu.org/main/advice> Accessed 27.08.03

The Students Union were aware of a few students with mental health problems using this service. Some came for advice when they were being asked to take time out from their studies. The advice worker also offered training sessions to college Welfare Officers.

¹⁴ Based on research interviews 2000-2003

The university's Disabled Students Officers were able to offer advice on reasonable adjustment for students with mental health problems, however very few Oxford students identified themselves as having a mental health disability.

The Disability Office can help by liaising with your college and department to organise your support needs. A discussion with your college would look at all areas of university life, including lectures, tutorials, examinations, and college accommodation. Disabled students are advised to discuss their needs before starting a course of study, but you can discuss any aspect of your needs at any time during your university career.

<http://www.admin.ox.ac.uk/eop/disab/webguide.shtml> Accessed 27.08.03

4.2.5 Support from Counselling Services at Oxford University

Students at Oxford University had access to psychological support from the Counselling Service. Twelve counsellors were employed, of whom eleven were interviewed. Two of these described themselves as psychologists rather than counsellors. Three were full-time and nine part-time employees. Three colleges had also engaged a part-time college counsellor of their own, but all had access to the central Counselling Service in Wellington Square. Annually between 700 and 800 students were seen, roughly 5% of the total population¹⁵.

The counselling staff encountered the full range of emotional and mental health problems amongst their clients. Students approached the Service direct, and sometimes tutors or other university staff would approach the Service on the student's behalf. In some cases staff turned to the counsellors when they felt that a crisis point had been reached, but this could lead to inappropriate referrals.

There is a danger of others in the university seeing the counselling service as an emergency service or crisis support unit. When student problems reach that level it is a medical need, and all the counselling service can do is to support the work of GPs or psychiatrists who should be the first port of call.

Counsellor OXU 003 193-197

Counsellors' decisions about whether or not to offer ongoing support to a student client were based on similar criteria to those used by their counterparts at Oxford Brookes University. At the lesser end of distress, no student who approached the services was seen as inappropriate. However, some students were judged to need ongoing tutorial support rather than counselling. One counsellor estimated that 20% of referrals fell into this category. At the other of the spectrum, counsellors would refer on students who they felt needed long-term therapy, were in a psychotic state, had

¹⁵ University of Oxford Counselling Service Reports

addiction problems, had severe eating disorders, were severely depressed, or were seen as posing a risk to themselves or to others.

Although the Counselling Service offered short-term therapy, counsellors were prepared to see some students over a longer period. In some cases they felt that they needed to operate a 'holding operation' for students who faced several months' wait for NHS psychotherapy, in others the students had long-term support needs that weren't being met elsewhere (see Appendix 4.2.6). Annually around 45% of students who booked an appointment were seen for between one and three sessions, around 30% were seen for four to seven sessions, around 13% were seen for 8-15 sessions, roughly 4% were seen for sixteen or more sessions. Another 8-10% did not turn up for their first appointment.¹⁶

The Counselling Service employed a part-time psychiatric consultant and counsellors were able to use this person to check their own concerns about students who might need psychiatric help or were considered at risk of suicide. The two occupants of this post during the research period stated that the work had an element of containing the anxiety felt by the counsellors. In some cases a discussion between the counsellor and the consultant was enough, in others the consultant would meet the student for an assessment interview. The role did not encompass delivering psychiatric treatment to the student. However, the consultant was able to speed up the process of accessing psychiatric services by lending weight to any request made by the student's GP for assessment by the local Community Mental Health Team. One of the consultants, who was also part of a local CMHT, was able to arrange direct access to psychiatric services for severe conditions, thus by-passing the role of the GP as gate-keeper to secondary services.

My role at OUCS is very different - assessing students for severe mental illness, assessing students' suicide risk and seeing the less severe end of mental illness to see what I can suggest. Much of the work is about relieving the anxiety of counselling staff who fear that they may be out of their depth with particular clients.

Psychiatrist NHS 003 10-13

In common with the counsellors at Oxford Brookes University, those at the University of Oxford gave in-depth descriptions of the many forms of support which they offered to students. These are summarised in Table 4.11 below.

¹⁶ University of Oxford Counselling Service Reports

Table 4.11 Examples of support offered by counsellors at Oxford University¹⁷

Asking questions of the student
Taking a history from the student
Asking about the presenting problem
Asking about their current academic and social situation
Helping the student to 'say the unsayable'
Seeking the cause and meaning of the student's problems
Helping the student to achieve insight into their problems
Helping the student to become aware of patterns of feelings or experiences
Looking for the replaying of issues within and outside the consulting room
Looking for things that the student is unconscious of and bringing them to their awareness
Helping the student to link current problems to past experiences
Challenging the student with paradoxes and analogies
Working with transference and counter-transference
Helping the student through immediate problems or crises
Helping the student to gain autonomy and to move on
Providing the student with a sense of security and stability
Creating a working alliance/trusting relationship with the student
Supporting the student in working through issues with their parents
Helping to contain the situation for the student and the university
Providing a safe place to look at what is going on
Helping to reassure the student that they are not going 'mad'
Reassuring the student that they are not a failure
Helping the student to use their intellect to support their emotional development
Offering longer-term support for e.g. depression, self-harm, eating disorders
Helping to deal with social/interpersonal aspects of e.g. manic depression, mild personality disorder
Asking the student what they would like to focus on
Working up a formulation of the situation with the student
Asking the student to rate (from 1-10) the extent to which they want to change something
Teaching relaxation techniques
Encouraging the student to keep personal records/diaries
Looking at the processes and beliefs that underlie the student's thoughts
Looking for thinking and behaviour patterns that are unhelpful
Helping the student to change their thinking patterns
Helping the student to focus on and change a particular aspect of their behaviour
Referring the student for psychiatric/medical assessment

¹⁷ Based on research interviews 2000-2003

The types of help offered to students by counsellors show the range of approaches used. Nine of the eleven counsellors interviewed were psychodynamically trained. However, only one of these worked in a purely psychodynamic way. Five included cognitive behavioural therapy (CBT) techniques into their work. One included some behavioural and systemic approaches alongside the psychodynamic approach. Another described himself /herself as 'eclectic with a psychodynamic base'. Of the remaining two (non-psychodynamically trained therapists) one was a CBT specialist, and the other a behavioural therapist who also used CBT techniques. The CBT specialist had been engaged for a one year trial at the suggestion of the Counselling Service's Steering Committee. The Service included specialists in exam stress/study skills, stress management and relaxation, and eating disorders. The majority used psychodynamic techniques as shown by the many items in Table 4.11. The latter part of the list demonstrates some cognitive and behavioural techniques. Those counsellors who used more than one approach made their choice according to the type of client or the nature of the problems being addressed (see Appendix 4.2.6).

Some local health service practitioners had the impression that the Service was overwhelmingly psychodynamic in orientation (see Appendix 4.2.6), even though many of the counsellors used a range of techniques including CBT. They were dubious of the benefits of psychodynamic therapy. This may be indicative of professional rivalry and suspicion between different types of practitioners, a point that is picked up in the next chapter.

One respondent felt that any debate on therapeutic approach was in danger of being too focused on the theoretical factors, when other factors might be at least as important in determining the quality of the student's experience of counselling.

The result of the therapy is dependent on the therapeutic alliance. With this age group, they are feeling their way through developmental issues and need time to talk and get clarity, so you don't need to make dramatic revelations, but you are always listening out for underlying stuff. It is more about interaction and exchange.

Counsellor OXU 012 99-103

Staff interviewed in the colleges and other departments of the university were aware of the Counselling Service and recommended students to use it. Inevitably there were some students whose needs were not met by counselling, whilst others found it to be a positive experience (see Appendix 4.2.6). Respondents outside of the service expressed concern that it was stretched and had to operate waiting lists. Counsellors stated that having to keep waiting lists down whilst working within resource limits

reduced their ability to meet the needs of students who would have benefited from longer-term therapy.

In common with the counsellors at Oxford Brookes University, some of the counsellors at the University of Oxford felt that there would be benefits arising from a closer relationship with the academic community.

The Counselling Service can help to inform the university on policies and practices. They need to get more institutionally involved to do this. Counsellors need to be involved at a policy level that academics don't see as appropriate. There seems to be no institutional value placed on how counsellors can help the wider university improve.

Counsellor OXU 003 155-206

There was also a desire for information and expertise to flow back the other way.

Oxford has academic experts who don't share their expertise on mental health with the counselling service. Why is there this split between the academic and the service delivery aspects?

Counsellor OXU 008 200-202

4.2.6 Support from medical services at Oxford University

Most colleges employed a college nurse who was sometimes involved in providing support, depending on their abilities to deal with mental health issues. Some of the nurses were seen as either getting out of their depth, or becoming over-involved and creating dependence (see Appendix 4.2.7). One college had a nurse with a mental health nursing background and found her to be a great asset. This nurse was able to take a proactive role with students who were seen to be at risk or to need additional support. As college employees, nurses found themselves in a difficult situation when other college staff wanted information about distressed or disturbed students.

Table 4.12 Examples of support offered by a college nurse¹⁸

Listening to the students' problems
Approaching students who are depressed or who display bizarre behaviour
Offering support
Offering interventions suggested by the College Doctor
Providing ongoing support to some throughout their degree
Monitoring vulnerable students for signs of degeneration
Helping students to keep taking daily medication
Providing information on exam stress and anxiety

¹⁸ Based on research interviews 2000-2002

Offering a safe space to talk about non-disclosed mental health problems
Helping students to access financial aid
Supporting students with stress and sleeping problems
Encouraging students to go home for a break
Encouraging students to approach the College Doctor or the Counselling Service

The nurses provided a link with the College Doctors who had a close relationship with individual colleges. The nurse would refer a student on if she judged their problems to be severe. The support provided to students at the University of Oxford by GPs is considered in Chapter 6. The university also employed occupational health physicians who could become involved in assessing certain students (usually graduates working in laboratories) suspected of having serious mental health problems (see Appendix 4.2.7).

4.2.7 Satisfaction with support at Oxford University

The structures and culture of college life often enabled students' problems to be identified and support to be offered. The downside of this was that some students feared their problems would become widely known within the college community. This perception caused some students to keep their difficulties to themselves. Student volunteers at Nightline attending a workshop run by the researcher had examples of mental health issues raised in confidence by a student with college nurses and college doctors being fed-back to college staff. The same point was made by one of the welfare officers interviewed. This made it difficult for them to advise students to use these sources of support.

Many college staff were willing to provide social support to their students. However, that support often involved sharing information about the student with other staff, either informally or in meetings such as college pastoral/welfare committees. There was a tension between alerting other staff to vulnerable students and respecting their need for confidentiality (see Appendix 4.2.8). This issue particularly affected counsellors, colleges nurses and college doctors. A number of colleges have started to introduce policies on confidentiality of personal information in response to these concerns.

The students interviewed felt that the support offered by tutors was variable, in some cases they were very good, some were not seen as approachable and some were seen as a major source of stress. Feedback from counselling and healthcare staff

confirmed this view. Four of the counsellors interviewed stated that certain tutors would refer students to them whose needs could have been met within a supportive tutorial relationship:

... there seems to be two types of response from other staff e.g. tutors:

Wanting to get rid of the student as quickly as possible and not engaging with their problem, e.g. if the student break down into tears. So they send the student straight on to Counselling.

The other response is from those tutors or others who are inappropriately trying to do too much, perhaps using limited counselling skills ... Without awareness, staff can develop false dependency relationships with students, or in good faith set up relationships with student whose needs they can never fulfil. This situation can be serious when they get out of their depth and there is a crisis, the relationship breaks down and they demand and expect immediate help for the student from the Counselling Service ...

Whilst some academics go to the extreme of saying 'never bring any personal problems to me however trivial', others go too far the other way.

Counsellor OXU 003 48-71

In the view of some college staff, counsellors and healthcare staff, the supportive nature of some colleges combined with a degree of separation from the external world, enabled some very vulnerable and disturbed students to continue with their studies despite their problems.

Some are so clever they are 'over the top and on the other side'. We have one male graduate student at the moment who has stayed on in college from his undergraduate time as he wouldn't survive elsewhere, not even in the college's graduate annexe. He will no doubt stay here as a professor!

College Staff Member OXU 018 119-122

Whilst there were positive aspects to this situation (examples were given of students who achieved degrees despite severe conditions such as schizophrenia), some healthcare staff and other respondents expressed their anxiety that such colleges were tolerating behaviour indicative of severe mental illness for too long. The perceived result was that when some Oxford students accessed psychiatric treatment, their problems had become more severe and deeply entrenched, whereas earlier intervention would have led to more positive outcomes.

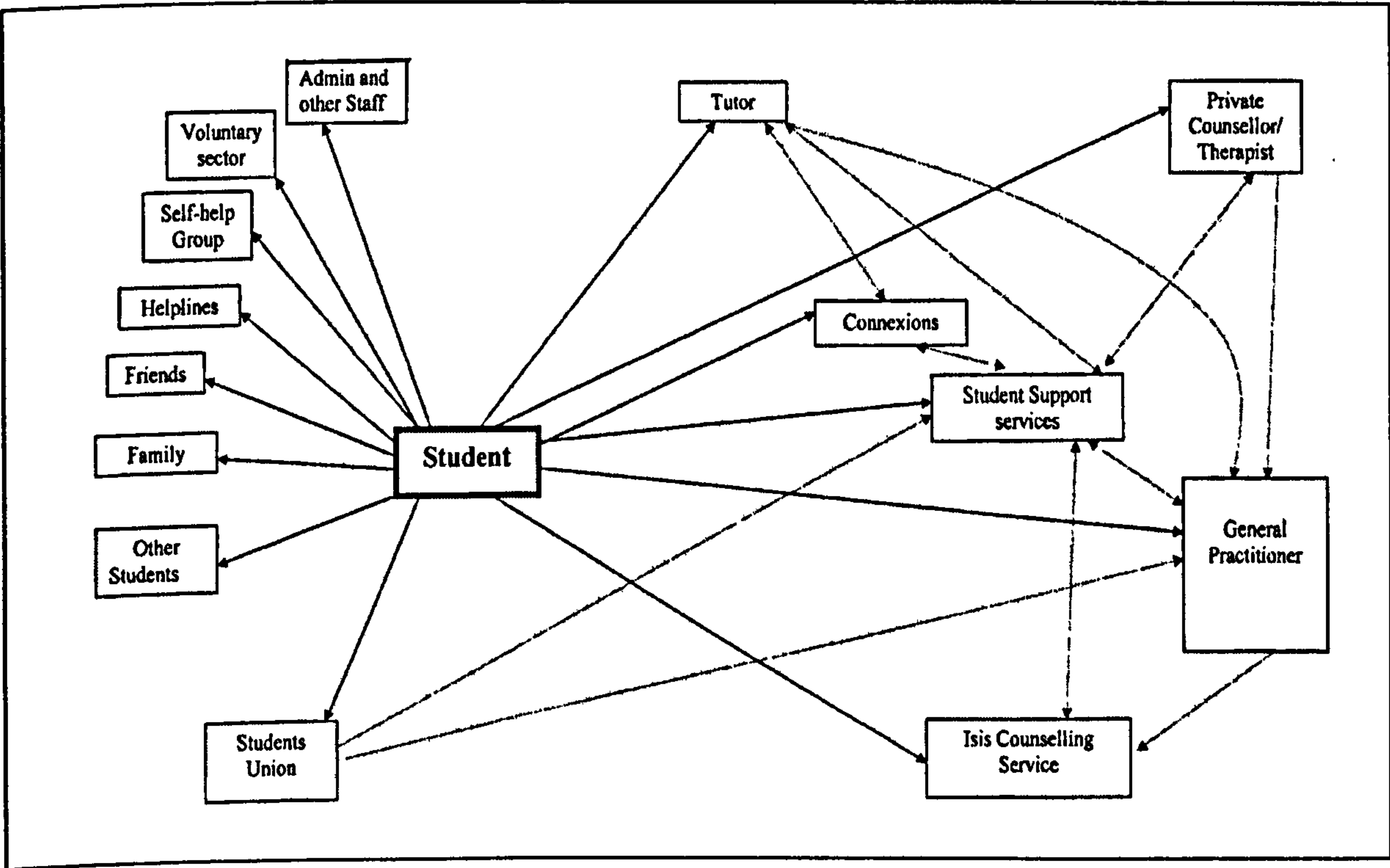
In contrast there were some colleges who were felt to go too far the other way, wanting students to return home if there was any indication that they might have a mental health problem. In 2002 the university adopted a Mental Health Policy in order to encourage a more consistent approach and to help colleges meet the requirements of the Special Educational Needs and Disability Act.

4.3 Support within Oxford College of Further Education

The College of Further Education had many part-time students enrolled, some just attending for a few hours a week. Nevertheless there were students, full-time and part-time, for whom college life was a significant part of their lives.

Support within the College of Further Education was limited compared to the local universities. This probably reflected the lower numbers of full-time students and the more limited financial resources available in this sector. Each student was assigned a personal tutor as their main source of support. However, as at Oxford Brookes University, each tutor could be responsible for many students. Only two tutors and one adviser were interviewed at the College, plus one former student (now at Oxford Brookes University), so less information was collected about support there than at the other institutions studied. Additional background information came from meetings with two other members of staff in connection with the work of the Oxford Student Mental Health Network.

Figure 4.3 Support available to students at Oxford College of Further Education



At the start of the research period, the College employed a nurse/counsellor who had a background in psychiatric nursing. Two part-time counsellors and two counsellors in training worked with the nurse/counsellor at this time. Owing to funding difficulties the posts were not sustained 18 months later when the nurse/counsellor took up another job. A part-time counsellor was brought in to offer a few sessions each week

but there was a significant drop in the level of support available. However, students up to the age of 19 were able to use the Connexions Service’s Personal Advisor for support. The College was not linked to a medical centre and students used their own local GPs. Specialist provision was made for students with learning disabilities who attended tailor-made courses at the college. The college had a small students’ union, but it lacked the resources of its university counterparts and did not employ advisory staff. The Head of Student Services was available to address some of the student support issues that could not be managed by other staff.

4.3.1 Support from tutors at Oxford College of Further Education

As shown in Table 4.13 students were more likely to use their tutor for support than any other source.

Table 4.13 Further education students’ use of services in Oxfordshire

<p>In a (2002) survey of Further Education Students in Oxfordshire</p> <ul style="list-style-type: none">• 5% had received counselling or other help for depression or other emotional problems in this term• 17% had received counselling or other help for depression or other emotional problems in the past• 45% had accessed support from their personal tutor• 6% had used their college’s counselling service at some time• 3% of males and 2% of females had visited a doctor in the last 6 months for depression, worry, anxiety or other emotional problems <p>Schools Health Education Unit 2002 <i>Further Education Student Health and Lifestyle Survey – Summary Report for Oxfordshire Colleges</i> Exeter: SHEU</p>

Both of the tutors interviewed regularly encountered students with existing or developing mental health problems. Support was offered to these students but there were perceived risks.

Mostly when things come up, your instinct is to deal with them. But the danger is you may not notice where it is leading until you are well stuck in and floundering. And you may not pass it on until you are floundering, which may be a mistake.

Tutor OFE 001 24-27

Other support staff in the College also identified the tendency for tutors to become over-involved and out of their depth with some students.

The tutors emphasised the positive aspects of being at college for students with mental health problems and the importance of providing a normalising experience. They referred students on to, or liaised with: GPs, social workers, community nurses

and learning disability teams. The main reason for attempting referral, according to one tutor, was the apprehension that a student was experiencing psychotic problems. The student adviser had referrals from tutors who feared that certain students might attempt suicide. Both tutors were frustrated by the reluctance of healthcare professionals to take on referrals or to share information about student-clients (see Appendix 4.3).

Students could access support in their community and, being local, were more likely to do so than university students, the majority of whom were new to the area and in temporary accommodation. Some of the students had come to the college after a period of support from local healthcare and voluntary organisations.

At the CFE, I was really open to staff about having a mental health problem. I was on a lot of medication and as I was relatively ill, didn't want people to think that was me. I didn't tell the other students, but did tell the tutors to make them aware as it was a big part of my life and because the medication affects length of concentration etc. The tutors were quite good, I guess, but as I knew about my health situation I didn't seek help. I just told them about it because of the effects on the work.

Student OXB S03 37-42

Users of mental health day centres in Oxford viewed further education as one pathway to recovery and re-integration (Pitts 2003). Respondents at the College and in the local mental healthcare organisations confirmed that this route was used by a significant number of service users.

Table 4.14 Examples of support offered by tutors in further education¹⁹

Talking to students
Asking questions
Building up a trusting relationship
Offering ongoing support for their studies
Taking into account the effects of illness and medication on the student's work
Asking the student for consent to share information with other potential supporters
Referring students for counselling
Trying to access support from external agencies
Offering courses in confidence building and anger management
Providing a normalising experience

¹⁹ Based on research interviews 2000-2003

4.3.2 Support from counselling and advisory staff at the College of Further Education

In the year 1999-2000, fifty-seven students were offered counselling, of these 31% were judged to have depression and 8.7% anxiety. A further 14% presented with relationship problems²⁰. The Nurse/Counsellor’s psychiatric background enabled him/her to assess students’ mental health needs and access additional support on their behalf. Three to four cases a year were dealt with in this manner. Having someone with a mental health background on site was appreciated in the College and by healthcare staff:

The College Nurse did a good job in supporting an Assertive Outreach client at the CFE, it seemed very positive and she/he knew what to look out for and who to contact.
Mental Health Care Staff Member NHS 023 88-89

Advisory staff with responsibility for monitoring and addressing non-attendance picked up some students with emotional and mental health problems. Younger students were able to access the Connexions advisors either directly or through referral.

The Connexions service is very good as it provides support for young people in their transitional years into adulthood and would advise young people thinking about going to college. It is a service that needs supporting.
Psychiatrist NHS 022 89-91

Table 4.15 Examples of support offered by counselling and advice workers at the College of Further Education²¹

Asking questions and identifying problems
Establishing the needs of students with identified mental health problems
Offering one-to-one support sessions
Liaising with tutors to meet the students’ needs
Helping the students to get special arrangements e.g. extra time in examinations
Obtaining GP support at times of acute illness or distress
Liaising with external agencies on the students’ behalf

4.3.3 Access to medical services at the College of Further Education

As the College did not have links to a particular Health Centre or GP Practice, staff had to encourage students to use their local GPs. This was felt to be an uncertain

²⁰ Oxford College of Further Education Counselling Service Annual Report.

²¹ Based on research interviews 2000-2003

process. One tutor was very critical of a number of GPs who did not act upon his/her concerns about students with mental health problems. Another also stated that medical help was not always available. When a collaborative approach from General Practitioners was encountered it was appreciated and helped college staff to continue supporting students with severe problems (see Appendix 4.3).

4.3.4 Satisfaction with support at the College of Further Education

With a limited number of respondents, it is difficult to draw firm conclusions about the quality of support offered to students with emotional and mental health problems at the College.

The picture that emerged from the research was that, in common with the two local universities, tutorial support was variable in availability and quality. Many respondents identified the need for tutors to have more training in mental health issues. This was not always to help them become more involved. There were suggestions for training around boundary issues, as some tutors were felt to have become inappropriately over-involved with distressed students. Nevertheless, the support offered by tutors enabled some students to complete their courses despite experiencing considerable problems.

The loss of the specialist nurse/counsellor was seen as a backward step in an institution that was well-placed to be a stepping stone to recovery and re-integration for service users. Although social support was reasonably strong at the College, access to psychological and medical support for the more distressed students was problematic.

4.4 Summary

The case studies presented illustrate the complementary part that different levels of support can play in assisting students with emotional and mental health problems. Although the three educational institutions studied were very different in nature, similar issues arose for those people who were involved in supporting students.

Within the universities and colleges there were informal levels of social support provided by friends, fellow students and members of staff who happened to become involved with the students. These institutions also provided more formal support at a social level through tutors, advisers, disability staff, residential staff, student welfare representatives and peer supporters. The nature of the social support provided included listening to the student's problems, providing reassurance and practical support,

showing concern and identifying other sources of support. Social supporters tended to recognise the limits to the support they could offer, but sometimes found themselves continuing to support a student because that person was unwilling or unable to access other forms of support.

At the psychological level, the two universities had counselling services and the college of further education provided access to counselling which could offer support to students who were emotionally distressed or who had low levels of anxiety and depression. Although a range of psychological approaches were offered, psychodynamic techniques were widely used. Other techniques included cognitive, behavioural and problem-solving approaches. The approach chosen was affected by a number of factors including the counsellor's training, the nature of the problems presented and the amount of time available for therapeutic sessions. The psychological support offered included: clarifying what the problem was, exploring underlying difficulties, helping the student to explore options and develop strategies, normalising the student's experiences and building a trusting relationship with the student.

In some case counsellors judged that the student's problems were too deep-seated or severe for them to manage alone. Some counsellors felt that they could support students with psychotic conditions, whereas others did not. Both university counselling services employed a part-time psychiatric consultant to help them manage the boundary between the need for counselling and the need for psychiatry. Both universities had links with primary care practices which provided access to medical support for their students.

Counsellors in educational institutions played a role at the interface of psychological with social and medical support. In the opinion of many counsellors certain academic staff could have done more to support students experiencing 'normal distress', whilst others should have been more wary of opening up areas that belonged to the realm of counselling. Counsellors were critical of GPs who relied solely on medication for treating conditions such as anxiety and depression, contrasting them with those who were 'psychologically minded'. In their turn some healthcare professionals were dubious of counsellors who offered anything other than a cognitive behavioural approach. Student welfare officers and peer supporters also came in for criticism or concern from medical staff for taking on issues that were too deep for them to handle. Residential staff found the refusal of counselling and medical staff to share information with them frustrating and limiting to the help that they could offer.

Despite these critical views from members of one sector in relation to another, almost everyone interviewed felt reassured that there were other layers of support. These were needed so that they could refer the student when they felt a situation was beyond what they could or should deal with. Referral 'upwards' at the point of a problem emerging or re-emerging, i.e. from social to psychological or medical support, or from psychological to medical support, was a much clearer pathway than the reverse. When the student was in recovery or had used up the resources available in the healthcare or counselling sectors, there were no clear pathways back into the realm of social support. Referral from medical services to psychological or social supports within the universities and colleges tended to rely on the efforts of particular individuals rather than being systematised and understood by those involved. This is an issue which is developed in the next chapter on the support offered by healthcare institutions and their interactions with academic institutions.

Chapter 5 Findings: Provision of Health Service Support

Whereas informal and formal social support could develop naturally from contacts within a student's residential or academic environment, health service support would usually have to be accessed deliberately. The decision to use health services to address emotional and mental health problems was influenced by a number of factors including: the severity and urgency of the student's problems, their support preferences, or a student's feeling that other avenues of self help and non-medical support were not making any difference to their condition. In extreme cases the decision would be made for the student e.g. as a result of serious self-harm, attempted suicide, or suspected psychotic disorder.

5.1 Access to health service support

Access to local health services provided students with opportunities for medical treatment (mainly drug treatment) and psychological treatment. Primary care medical support for students in Oxford was available from general practices and health centres, mostly those linked to particular colleges or university campuses, and from others sited near the students' place of residence. As with general populations a series of filters operated (Goldberg and Huxley 1992). Not all of the students with emotional and mental health problems would approach their General Practitioners (GP).

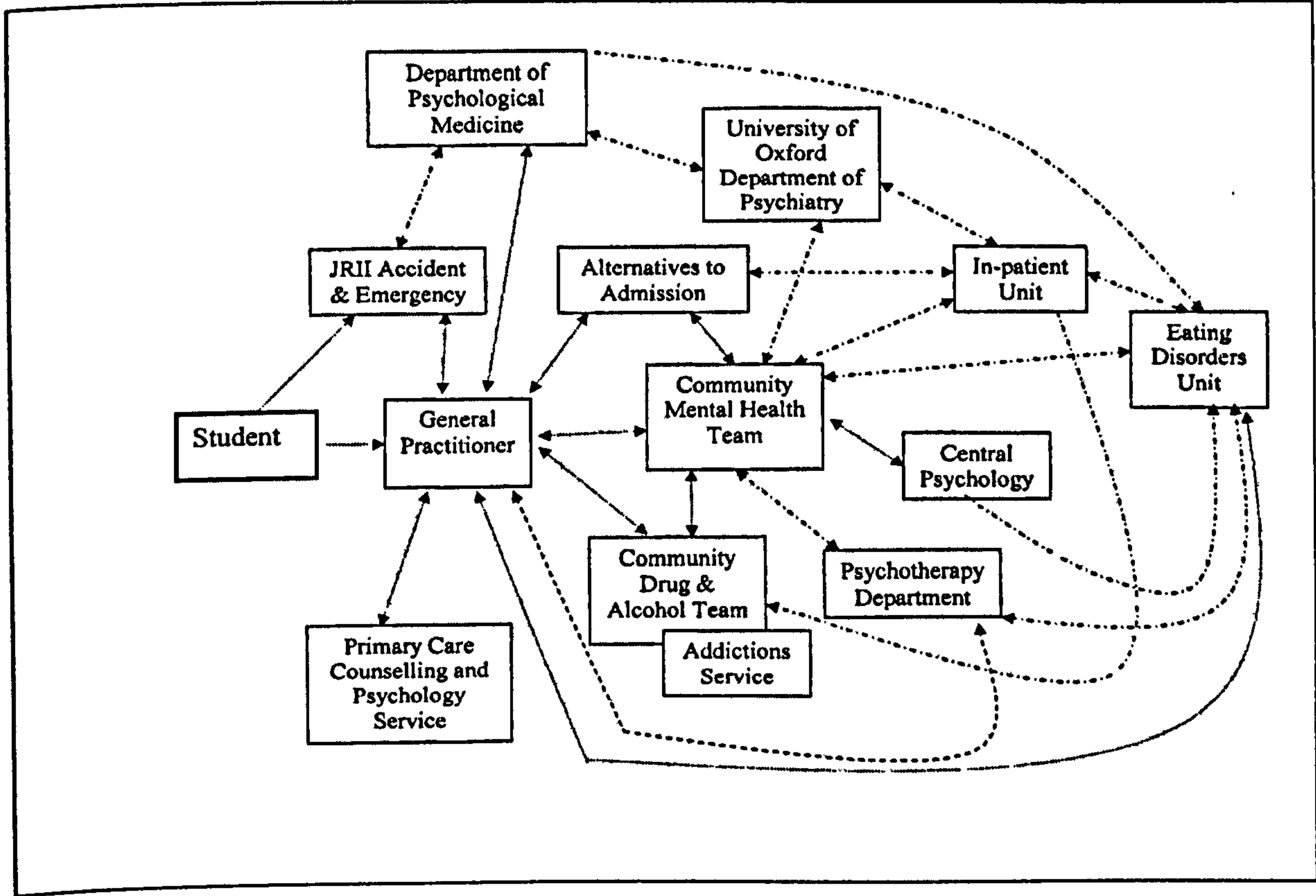
The problem is persuading students to do something about their problems.

College Staff Member OXU 019 121

If approached by students, GPs first had to assess whether or not they had a mental health problem. Next GPs had to decide whether they could treat the student, refer them on for counselling from either the Primary Care Counselling and Psychology Service or their university counselling service, or refer them for further assessment from one of three local Community Mental Health Teams (CMHTs) at the secondary care level. Assessments could also be carried out by the Alternatives to Admission team. Students who were acutely ill could be admitted to one of the local psychiatric in-patient units, either voluntarily, or on a Section (compulsory admission under the 1983 Mental Health Act). Students under 18, mainly those in further education, would be referred to the Children's and Adolescent's Mental Health Service. These services were also at the secondary care level.

Students who committed serious self-harm or attempted suicide, having been treated for their physical injuries or overdose by the Accident and Emergency Unit, were assessed by staff from the Department of Psychological Medicine, a tertiary mental health service, and would often be referred back to their GP. Other tertiary services included further specialist provision which is detailed later. The University of Oxford Department of Psychiatry conducted research and teaching in psychiatry and offered specialist services at the Warneford Hospital. According to one respondent this Department was more likely to be accessed by Oxford University students than those from Brookes. Students' pathways into these mental health services are illustrated in Figure 5.1.

Figure 5.1 Provision of Primary, Secondary and Tertiary Mental Health Support in Oxford¹



Respondents commonly reported that access to tertiary services was limited owing to resource issues (Appendix 5.3.1). However, if the student's needs could not be met by secondary mental health services alone, and their condition was having a severe impact on their life, they could be referred for specialist treatment. Following treatment at tertiary level students would be referred back to CMHTs or their GP.

The following sections of this chapter explore students' access to, and support offered by, health services at primary, secondary and tertiary levels. Brief mention is

¹ Based on research interviews 2000-2003

also made of voluntary sector mental health services which often worked in collaboration with statutory services.

5.2 Oxford City Primary Care Trust

5.2.1 Detection of problems at a primary care level

In Chapter 4 we saw that some students were reluctant to seek medical help for their emotional and mental health problems, whilst others preferred to take that route rather than talking to friends or seeking counselling. General Practitioners were the main access point to mental health services and were generally seen as crucial when a student was suffering from a severe mental health problem. However, GPs also emphasised that they were there for a whole range of life problems:

Approaching the doctor is never inappropriate. It is a ticket of entry.

General Practitioner NHS 002 71

The GP is the first port of call in primary care so GPs will always see students if they want to come. Every patient gets a fair hearing. This may not involve a follow up by the GP, a single session may be enough. Often the GP will advise the student about other support which they can access for their problem.

General Practitioner NHS 004 51-55

Students who were known to be experiencing psychotic symptoms or suicidal thoughts were likely to be referred to a GP with some urgency by social supporters or counsellors. However, there was a grey area concerning the treatment of less acute yet potentially serious mental health issues such as depression and anxiety. In these cases, either counselling services or general practitioners were often seen as a suitable source of support.

GPs confirmed that they saw a wide range of problems, not all of them medical.

[We see] the entire range of mental health problems. Compared with the community at large, students present with higher adjustment, loneliness and relationship problems but fewer with major psychotic problems probably because these are so disabling that they would make it difficult for someone to become a student. However, quite a few psychotic problems are seen.

Presentations can be seasonal, e.g. pre-examination anxiety and insomnia. Throughout the year the types of presenting problems I will see amongst students include adjustment problems, relationship problems, accommodation problems and also those students who are having problems with the university authorities. I will see a lot of eating disorders, quite a lot of anxiety and depression and some manic depression.

General Practitioner NHS 004 6-14

The three GPs interviewed saw the students' mental health problems as originating from biological, genetic and situational factors. Two GPs mentioned the

impact of the student's family on their mental health. They were all very aware of the pressures that students were under in relation to their academic situation.

5.2.2 Provision of primary care support

Respondents reported significant variances in approach between different primary care practitioners in treating common mental health problems:

Certain GP practices will send depressed students to the counselling service first, one or two do this regularly. Other doctors will prescribe drugs and suggest that the student seeks counselling. There are others where they only prescribe and don't refer to the counselling service. I feel that it is a hit and miss process.

Counsellor OXU 012 169-172

In Oxford different doctors have different attitudes to stress and depression e.g. there are those that just hand out tablets. I knew a person who was still depressed after being given anti-depressants and should have been offered other support by the doctor e.g. suggested referral to a counsellor.

Student Welfare Representative OXU S03 168-171

These comments were typical of a number which indicated that GPs had differing attitudes towards referring depressed students for counselling (Appendices 5.2.2. and 5.2.4). If students were referred for counselling by a GP, they were most likely to be referred to their own educational institution's service rather than the Primary Care Counselling and Psychology Service, mainly because of limited resources and waiting times for this service². The ISIS Centre took self-referrals for counselling and saw students from most of the local educational institutions, but the numbers seen were small compared with those who used the university-based counselling services³.

Of the three GPs interviewed, all were referring students with moderate levels of problems to their university or college counselling services. However, one of them felt that the psychodynamic approach did not work and would have been happier to have seen Cognitive Behavioural Therapy (CBT) being offered. The same practitioner was the only one to indicate the use of medication for common disorders at an early stage.

The students often start on medication in the first appointment as time is short when you're working with students in an eight week term.

General Practitioner NHS 002 116-117

² Oxford Student Mental Health Network Survey 2000

³ Oxford Student Mental Health Network Survey 2000

With such a small group of respondents it was difficult to draw conclusions about the support that was typically offered to students but the examples given are summarised in Table 5.1. One GP offered five one-hour support sessions each week for individual students, offering them what he called ‘amateur CBT’ because of the difficulty in accessing psychological treatment. Such in depth support was unlikely to be typical given the time pressures on GPs. However, the three GPs interviewed were all open to seeing students for ongoing support (Appendix 5.2.2).

Table 5.1 Examples of the type of support offered by primary care practitioners⁴

Listening to the student
Advising on other sources of support
Providing reassurance – ‘am I normal?’
Building a relationship with the student
Providing ongoing counselling support
Supporting a problem-solving approach
Introducing the student to self-help materials and books
Recommending exercise, sleep-hygiene and alcohol reduction
Writing a letter e.g. to get suitable accommodation or explaining why coursework has been affected
Giving medical support – providing medication
Reviewing the effectiveness of the treatment
Referring to other services e.g. counselling, psychotherapy, psychiatric
Liaising with the university or college with the student’s permission

The GPs commented on the differences in working with students compared with their other patients. Students were felt to have more intense and immediate presentations of mental health problems. They were more likely to be lonely, anxious and depressed. They were affected by seasonal factors such as the start of a new academic year or the pressures of the exam period. Students were often cut off from their families. One GP reported seeing a disproportionate number of freshers for this reason. Some students were felt to go a bit ‘wild’ in their first year, experiencing adverse affects from drink and illicit drugs.

With many students only being around in term time, GPs often felt that they did not have long to work with them. This also caused difficulties when appointments for assessment by secondary care services fell in the vacations.

⁴ Based on research interviews 2001-2003

5.2.3 Referral from primary care

An issue for all the primary care practitioners interviewed was access to secondary and specialist mental health services for their patients. There was particular frustration around not being able to obtain timely access to psychological and psychotherapeutic treatments:

The main problem is the length of the psychology waiting list ... More referrals are made to CBT but students have to wait two terms for an appointment. Their appointment may be in the vacations and consequently students fall off the list.

General Practitioner NHS 002 44-46

Access to treatment is a big problem and disappointing. Prior to the local NHS reorganisation we had a practice-based CMHT and it was very successful. Now we share a couple of consultants with several other practices so we are more hesitant to refer since we know the system is overloaded. The Practice will always refer those with severe psychiatric problems.

General Practitioner NHS 004 156-160

Despite the disappointment about the availability of ‘mid-range’ services, access to treatment for students with severe mental health problems was felt to be good by one GP, and another stated that those with acute problems would get seen (Appendix 5.2.3). This confirmed a point made by many counsellors and some practitioners within secondary and tertiary services, namely the necessity for prioritising referrals created the risk that some students (and other patients) would have to reach crisis point before being able to access appropriate services.

There are more students [than previously] who are not able to function very well, have low self esteem, much depression and anxiety and go down and down. If they had received CBT earlier they would have been able to function.

General Practitioner NHS 002 193-195

5.2.4 Primary care working with the academic institutions

All three GPs interviewed recognised the value of collaboration with the student’s academic institution. There were a number of instances of GPs making contact with the student’s academic institution in order to support the student in continuing with their studies. Those mentioned by the GPs themselves are set out in Table 5.2 below (also Appendix 5.2.4).

Table 5.2 Examples of General Practitioners’ contact with academic institutions⁵

Writing to request residential accommodation
Providing a letter to explain delayed coursework
Asking tutors to reduce pressure on the student
Discussing the student’s situation with student services staff (if the student gives their permission)
Discussing the risk of suicide with student services (with or without the student’s consent – depending on the level of perceived risk)
Referring students to the academic institution’s counselling service
Arranging additional support from a college nurse
Advising on suitability to study (on mental health grounds)

Respondents other than GPs also commented on the relationship between doctors and staff within academic institutions. Overall, the relationships between GPs and individual colleges within the University of Oxford seemed much closer than those with the various departments or sections within Oxford Brookes University.

The relationship between certain GPs and university/college counsellors was not always straightforward.

Yes there are issues. One is that there is not enough liaison with health services including the university’s medical centre. This makes for problems when there is a need to access a GP. I am always left wondering if it is OK to contact the GP, and I never had a GP approach me as a counsellor to liaise over a client.
Counsellor OXB 006 127-130

Some GPs were seen as doubtful of the value of counselling, whilst some counsellors felt that certain GPs were unnecessarily medicalising students’ life problems (Appendix 5.2.4 and Chapter 4 section 4.2.6).

5.2.5 Views on the quality of primary care services

Respondents expressed a range of opinions on the quality of the services provided at primary care level. One key issue was prompt access to a General Practitioner. A fast response to problems was appreciated, as was access outside of surgery hours (Appendix 5.2.5).

It is not only difficult to maintain confidentiality it is difficult to be seen to be doing it. I think our college doctors are particularly good. They offer the senior tutor their home numbers and if a student knocked on the door who was obviously psychotic or depressed I would feel confident that

⁵ Based on the research interviews with GPs.

they could do something. The fact that they do offer their home numbers is a revelation and, as well as this, they also offer a whole set of guidelines on what to do in an emergency.

College Staff Member OXU 023 181-186

Respondents were frustrated when they felt that GPs were difficult to access or were not responsive to their requests for support. This frustration tended to be expressed more by staff from Oxford Brookes University and Oxford College of Further Education, rather than those at the University of Oxford who seemed to have more direct access to primary care through their College Doctors (Appendices 4.3 and 5.2.5).

Where a close relationship existed between a college or a university department and a particular medical practice, it was valued. However, some students were concerned about the links between their institution and their doctor and had suspicions that sensitive information might be fed back:

The college relies on GPs informing them of problems, but if someone [i.e. the student] gets a whiff of this, they then seem to be containing problems rather than having an interest in welfare.

Student Welfare Representative OXU S06 274-275

Linked to this issue, one of the main themes arising from respondents' comments on primary care was that of choice, and in particular students' awareness of the choices open to them. Some students may have felt more comfortable being treated by someone unconnected to their college or university. Others were influenced by their perception of particular GPs, whether they found them sympathetic or not, and their faith in the GP's ability to deal with emotional and mental health problems (Appendix 5.2.5).

Maybe 60% of college doctors are psychologically minded. I respect their medical training and tell students to consult their GPs, but they are not trained as counsellors and can only do so much in 10 minutes.

Counsellor OXU 016 57-59

Another area of dissatisfaction with primary care services related to the choice of treatment offered for common mental health problems (Appendices 5.2.2 and 5.2.5). Although there may be less choice when it comes to treatment for very severe mental health problems, it was found that anxiety and depression could be treated by either medication, counselling or a combination of the two. Research interviews indicated that not all students were made aware of, or offered, these choices. Many of the healthcare staff interviewed, and some of the students, would have liked a wider range of therapeutic approaches to be available, especially Cognitive Behavioural Therapy (CBT). However, owing to NHS resource constraints and the preferred orientation of

university counselling services, CBT was only available to a few students (Appendices 5.3.1 and 4.2.6). In the case of services for students at Oxford Brookes University, the situation was felt to have been made worse by local health service re-organisation:

If a GP feels that CBT would help, then they can refer to XXX [named individual] in the Primary Care Counselling Service. However, she/he can only see one new patient a fortnight. Previously the Practice had a number of psychologists and could offer a quick service. Previously, as a fund-holder Practice, we could buy in the services we needed. The change to PCT happened in the name of equity but was a backward step for this Practice's patients.

General Practitioner NHS 004 166-171

Overall, the provision of primary care services for students with emotional and mental health problems in Oxford could be described as variable in quality. There were GPs who were very active on behalf of their student patients and who were prepared to look at a range of support options. Research respondents had also encountered GPs who were either not seen as sympathetic, or who were perceived as being too ready to prescribe medication without exploring other options. One psychiatrist interviewed felt that there was also variation in GPs' ability to make appropriate referrals:

Not all referrals are appropriate. I would not have referred some of the clients when I was a GP. There is a need for education about referrals. GPs need to look at what they can offer. Some GPs are very good, others don't have the right attitude and that could be difficult to change as it is not just about information or knowledge.

Psychiatrist NHS 001 48-53

As general practitioners played a key role in the access to other medical and psychological treatments for emotional and mental health problems, this variability in practice was cause of concern for a number of research respondents (Appendix 5.2.5).

5.3 Oxfordshire Mental Healthcare NHS Trust

Within Oxford, secondary mental services were provided by three Community Mental Health Teams (CMHTs) and by in-patient units located at the Warneford and Littlemore Hospitals. These secondary services assessed and treated many of the students referred on to them by primary care services. If students' needs could not be met at this level they were referred on to tertiary mental health services (Figure 5.1). All these services were part of the Oxfordshire Mental Healthcare NHS Trust and were overseen by a clinical services manager for Oxford City. The Trust did not provide specialist services for students, nor did it have a strategic approach for meeting the needs of the local student population. However, certain teams and departments had a greater proportion of students amongst their patients than others and so were more

aware of student mental health issues.

5.3.1 Access to services

Access to secondary and tertiary mental health services was largely through GP referral. Rarely a student would be admitted on a Section (Mental Health Act 1983), involving the police and social workers. Respondents working in mental health services emphasised that they dealt with the severe end of mental health problems, especially psychosis, and expected or hoped that other cases would be managed at a primary care level (see the comments of psychiatrists and managers in Appendix 5.3.1). Many of the respondents felt that this left a gap in effective provision for many people with serious mental health problems such as: clinical depression, anxiety, phobias and personality disorders. One health service manager commented that the situation had worsened because thresholds for what constitutes severe mental illness were being raised:

Provision for those who fall between counselling and severe mental illness (SMI) services is certainly a grey area. In the last four to five years the government has targeted severe mental illness e.g. the NSF [National Service Framework] standards for secondary services, but the quality for SMI has been maintained or raised by raising thresholds for entry. And what has happened is a lack of services in the middle. Primary care has not the professional resources to fill this gap. It is not clear when funding will come from for this.

Mental Health Care Staff Manager NHS 016 30-35

In common with this response, much of the apprehension expressed by respondents was not about the quality of the services provided, but concerned the difficulty of accessing these services for all but the most urgent cases.

Table 5.3 Concerns about students’ access to mental health services⁶

Recognition of the severity of a student’s condition and subsequent referral to services would take longer when living in student accommodation than if they were with their family
Only students displaying very severe symptoms would be able to access psychiatric services
There could be discontinuity of care for some students already in treatment in their home town when they moved to Oxford
It was difficult to know how to prioritise students in relation to other groups in the community with pressing needs
Students in residence for short terms in Oxford needed speedy access but faced long waiting lists for psychological treatments

There were certain instances where healthcare staff felt they could have been alerted to students with severe problems earlier:

⁶ Based on research interviews 2000-2003

A case of a college not picking up on someone’s deterioration. He gradually deteriorated over five to eight weeks and was left to his own devices and nobody guided him to the GP or college doctor. He had been in his room for a week and was really unwell.

Psychiatric Nurse NHS 026 168-170

Urgent referral can happen with students, as everyone is so organised round course-work and if the student can still hand in essays, despite their weight being very low, then the GP, college nurse, or rarely tutors, will only refer them when things have got very bad. So there is tolerance of a higher threshold than would happen in other settings. They will let it go further and then it becomes more serious.

Clinical Psychologist NHS 025 16-20

Despite these difficulties, a significant number of students were using secondary and tertiary mental health services. Although local health service providers rarely had systems in place to record the numbers of students encountered, some research respondents provided information which gave a partial picture of students’ level of use of their services.

Table 5.4 Students’ use of mental health services⁷

Approximately 20% of the users of one Community Mental Health Team were students
Approximately 40% of patients on one ward were students
35 out of 88 patients either in treatment or waiting for specialist psychological treatment were students
Approximately half of the clients of the adolescent psychiatric service went on to further or higher education (there were around 380 patients in total)
20% of the patients receiving specialist treatment for eating disorders were students
One or two students were seen by the specialist drug and alcohol service

In the year 2000 the Department for Psychological Medicine saw 88 cases of self-harm amongst students including 22 students from the University of Oxford and 10 from Oxford Brookes University.⁸ As this service covered all of Oxfordshire it would have also seen students from a number of other further and higher educational institutions.

This research was not able to quantify precisely the numbers of students using the whole range of mental health services in Oxford, but Table 5.4 indicates that they formed a significant proportion of the users of certain services. It is worth noting that, despite reported high levels of drug and alcohol usage amongst students, very few were seen by the specialist drug and alcohol service.

⁷ Based on information supplied to OSMHN by practitioners 2001-2002

⁸ Oxford City PCT 2002 Student Health report

It may be that GPs will know of student services that they could use and will know about waiting lists and decide not to refer to us. It may be that GPs don't refer students, or that young people don't seek help.

Or that they don't present addiction as the problems when they come to the GP. They don't present with problems with drugs and alcohol e.g. a male student who went to the GP with depression and luckily the GP asked about alcohol use and realised this was the issue.

Or perhaps that we don't have the right 'vibe' within the student body. It would be useful to get a picture of how we are seen by counsellors and students etc.

Clinical Psychologist NHS 021 190-200

Closely linked to the matter of access to services was that of perceived gaps in the mental health services needed by the student population. A particular gap, mentioned by many respondents, was in the provision of rapidly accessible 'mid-range' psychological/psychotherapeutic services, which could provide deeper and longer treatments than were available from university and primary care counselling provision. This and other perceived gaps are summarised in Table 5.5 below.

Table 5.5 Perceived gaps in mental health provision for students in Oxford⁹

Co-ordinated and widespread preventative/mental health promotion work with student populations
Targeted and specialist mental health support for:
<ul style="list-style-type: none">• International students and students from ethnic minority groups• Students who were survivors of sexual abuse• Students who abused alcohol and drugs
Provision of intensive treatment for students with serious eating disorders which was compatible with continuing to study
Reduced levels of support for young adults upon leaving adolescent services
Ongoing support for students with mental health problems upon entering further and higher education
Accessible psychological services that bridged the gap between counselling services and services for severe mental illness

5.3.2 Provision of support by secondary and tertiary care services

As illustrated by Figure 5.1 earlier in this chapter, those students who required services beyond those provided at a primary care level would typically have had their needs assessed by members of a Community Mental Health Team (CMHT) or a hospital in-patient unit. Other pathways to care included the Alternatives to Admission team and the Department for Psychological Medicine. More rarely students might come to the attention of mental health services through the police, social services or practitioners of physical medicine.

⁹ Based on information collected from OSMHN's research interviews and work groups 2000-2003

Care at a secondary level was provided by hospital in-patient and out-patient units and by CMHTs. The role of the Psychology Department was slightly complicated as it was a tertiary service providing input to CMHTs as well as running Oxford's Primary Care Counselling and Psychology Service. Secondary care services could refer patients to tertiary services if there was sufficient severity and urgency of need for more specialised services. Tertiary mental health services included specialist provision for: eating disorders, self-harm and attempted suicide, substance misuse and addictions, as well as specialist provision of psychology and psychotherapy. These tertiary services had a strong psychological/psychotherapeutic element. Patients treated by tertiary services were typically referred back to secondary and primary care services for ongoing support.

Whilst psychiatrists dealt mainly with psychotic conditions, this did not mean that patients with schizophrenia or bi-polar affective disorder were treated by purely medical interventions. The clinical psychologists and psychotherapists working in the Trust made the point that they could work with a range of mental health problems including psychoses.

It would be appropriate to see some who have chronic psychotic illnesses, which are not in an acute phase. Appropriate, because we are all human and have experiences we need to make sense of.

Psychotherapist NHS 017 43-45

5.3.2.a Secondary mental health services

Secondary services provided a range of care including community-based and hospital-based treatment. Interview respondents in these services included psychiatrists, nurses and service managers. Each were asked to describe the nature of the support they offered or were responsible for managing.

The psychiatrists tended to state succinctly that they just followed standard procedures (Appendix 5.3.2.a), without going into great detail about what these were or why they were necessary. It is interesting to compare these statements with the responses of psychologists, psychotherapists and counsellors who tended to go into a lot more detail about which approach they adopted, what it entailed and its justification (Appendices 4.1.4, 4.2.8 and 5.3.2.d).

One psychiatrist suspected that some students, and perhaps others involved with them, were wary of his profession:

There are some clients including students who don't want to see a psychiatrist and in some cases it is possible to leave them to the OT and CPNs.

... There is a concern that statements about services to students don't reflect the effort that is put in. Perhaps it is more true of those waiting for psychological services rather than those with psychosis. Perhaps it is also linked to suspicion of psychiatry and the view that it shouldn't be necessary?

Psychiatrist NHS 006 60-61 & 141-144

The psychiatrists interviewed were fairly consistent, if rather brief, in their descriptions of the support they offered to student clients. The key elements are summarised in Table 5.6 below.

Table 5.6 Examples of support provided by psychiatrists¹⁰

Making a psychiatric assessment
Providing a diagnosis
Enabling a shared understanding of what is going on
Providing a range of interventions including medication
Reviewing medication
Providing support as part of a team
Referring the student for psychological treatment

Despite having to play a clearly defined medical role of assessment, diagnosis and prescription of treatment, all the psychiatrists interviewed were aware that there were also social and psychological factors which affected the mental health of their student patients (Chapter 3). These psychiatrists, based within Community Health Mental Health Teams and the Adolescent Service, were able to refer their patients to other team members for psychological and social issues (Appendix 5.3.2.a).

Respondents indicated that certain branches of the mental health services were more medically-oriented than others. One health service manager contrasted the experience of students treated within the academic Department of Psychiatry (the Professorial Unit) to those treated within a CMHT:

From a community mental health view of things, if you are a student going to Brookes you are likely to be allocated a CPN, whereas if you are at the old university you will have a consultant. I would argue that Brookes students will get a better deal with a greater range of professions available to work with that group. Whereas, in the Professorial Unit the approach is more medical and there is the potential for gaps there as people don't get the whole range of services possible. However, one of the good things about that Department is that it gives them access to trials and treatments that are on offer in the Professorial Unit, so will give access e.g. to CBT trials. I still have a niggle that it is much more medical than it need be.

Mental Health Service Manager NHS 014 88-96

¹⁰ Based on research interviews 2000-2003

Two psychiatric nurses, based in different in-patient units were interviewed. Despite working within a very medical setting, they felt that their nursing roles enabled them to take a broader approach compared to that of psychiatrists:

Doctors tend to look for symptoms, they want to label the condition. Nurses are more holistic and will look at psycho-social stuff e.g. what might have triggered the illness? And what their needs might be afterwards. They will link with people like XX [named individual] at Brookes [University] to consider their housing needs and financial problems.

Psychiatric Nurse NHS 015 64-67

The support offered by the two psychiatric nurses interviewed is summarised below.

Table 5.7 Examples of support provided by nurses in secondary care¹¹

Building trust with the patient
Assessing the needs of the patient during and beyond their stay in hospital
Assessing the patient’s functioning and levels of risk
Using generic counselling skills
Supporting the use of medication and the patient’s engagement with mental health services
Encouraging involvement in activities
Helping the person to move on from the crisis
Supporting the person in dealing with social problems such as housing
Offering support to carers and relatives
Linking the person to other sources of support

It is sad that acute provision is in a hospital setting and sad that hospital is seen as a last resort rather than as a good place for treatment. It is seen as a last resort by many users. Hospital settings have gone down in what they can offer because of the emphasis on community services. And so people feel bad about being in hospital because of the government emphasis on community services.

Psychiatric Nurse NHS 026 34-38

Both of the nurses were very aware that students (and other patients) could be very strongly affected, not only by the mental health problem itself, but also by the effect of receiving a psychiatric diagnosis and finding themselves in hospital. They felt that more could be done to support academic staff who might be in contact with students with mental health problems. Overall the nurses shared the psychiatrists’ understanding that social and psychological factors were important, but being less constrained by their role were able to be more holistic and less medically focused in their professional practice (Appendix 5.3.2.b). One nurse was very interested in Cognitive Behavioural Therapy and hoped that its use might be developed on the ward.

¹¹ Based on research interviews 2002-2003. See Appendix 5.3.2.b for more details.

CBT is another angle trying to find out what the patient thinks about it all. It is not about labelling but asking and exploring and weighing up evidence. It is a logical approach.

Psychiatric Nurse NHS 015 73-74

Four managers of mental health services in Oxford were interviewed. All were mindful of the fact that a significant number of the users of their services were, had been, or would like to become students. During the research period the Trust had considered appointing a psychiatric consultant specialist with responsibilities for students in Oxford, but decided against it as other consultants did not want to lose their contact with student patients (Appendix 5.3.2.c).

One team manager pointed out that there was an issue of CMHTs having students working with them from social work and nursing programmes who could find themselves treating fellow students, or being in need of psychiatric support themselves. At a strategic level service managers were aware of issues particularly relevant to the local student population (Appendix 5.3.2.c). A summary of the points made by the managers is given in Table 5.8 below.

Table 5.8 Key points made by managers about service provision¹²

The need for early intervention and more preventative work
Quicker access to CBT and psychotherapy generally to avert more serious mental health problems later
More service provision during term-time
The need for rehabilitation services that move people on and help them re-integrate into the community
The need for community-based services to keep people with serious mental health problems in education. Possibly using the assertive outreach mode

The mental health service managers interviewed were clearly very aware that students' mental health needs extended beyond immediate medical and psychological treatment to include support that would maintain them in their social and educational environment.

5.3.2.b Tertiary mental health services

Tertiary care respondents included both psychotherapists and clinical psychologists who worked in specialist areas linked to particular conditions e.g. eating

¹² Based on research interviews with service managers 2002-2003. See Appendix 5.3.2.c for more details.

disorders and substance misuse, or according to approach e.g. psychology and psychotherapy. The Psychotherapy Department was a stand-alone tertiary service, with some input to CMHTs, which took referrals from both GPs and secondary care services. The Psychology Department was mainly involved in providing psychological input to other services including Community Mental Health Teams.

Table 5.9 below sets out a summary of the support and interventions offered by those practitioners interviewed.

Table 5.9 Examples of support provided by tertiary care practitioners¹³

Providing a range of interventions including medication
Cognitive Behavioural Therapy
Cognitive Analytic Therapy
Brief Solution Focused Therapy
Systemic approach – looking beyond the individual
Working on improving the individual’s self-esteem
Providing support as part of a multi-disciplinary team or alongside other services
Referral to social workers for practical problems
Liaison with academic staff and college staff

The decision whether or not to offer psychological treatment was governed as least as much by resource allocation as by clinical judgement.

One role is to go to triage meetings to help decide which clients can come through for psychological treatment. We can only deal with around one in six referrals a week as there is a lack of resources. The decision is not purely about priorities or suitability for treatment as many would benefit. As there is a lack of resources, more will go to psychiatric treatment and be offered medical treatment first.

Clinical Psychologist NHS 024 10-15

Nevertheless, there were differing opinions between members of the mental health services on the merits of psychological and medical approaches to treatment.

The medical/biological view is there and different professionals vary in their view of psychotherapy. Some are quite against it and some are more in favour. I started work in an era when more value was placed on therapeutic communities. Mental health services have now become more medically oriented. I do have some clients under the care of a very biologically inclined consultant, but he has made the referral to our service. It does affect the type of communication possible, but there will still be reports made back to the consultant.

Psychotherapist NHS 017 130-136

¹³ Based on research interviews 2002-2003

Of the four practitioners interviewed working in tertiary care, one used Cognitive Analytic Therapy, one used Cognitive Behavioural Therapy, one used CBT with family therapy and group work, and one used what they described as ‘an integrated approach’ incorporating CAT, CBT, Brief Solution Focused Therapy, systemic work and motivational interviewing (Appendix 5.3.2.d). This latter practitioner felt that each approach had its place in treatment relating to the client’s past, present and future situation, but that the quality of the relationship between the client and the therapist was the main factor in ensuring a successful outcome. The same person saw dangers in an overly medical approach to treatment.

The old-fashioned medical philosophy is that something has broken and it needs mending. The psychological approach is about the whole system, them and those around them. Medicalisation promotes the danger of the tablet-taking culture. Whereas in the USA healthy behaviour is rewarded by avoidance of healthcare costs, here we want to get fixed after neglecting our health.

Clinical Psychologist NHS 021 251-257

The practitioner who used mainly CAT felt that it was a good tool for addressing past and present relationships and tackling unhelpful patterns of thought and behaviour which might otherwise persist in the future. This person felt that for some patients, CAT addressed underlying difficulties that were not touched by CBT, and had the advantage of being more structured than psychodynamic and group therapy approaches (Appendix 5.3.2.d).

The practitioner who used CBT with family therapy and group work was working with patients with severe eating disorders. This person commented on the need to treat both the eating disorder and self-esteem issues in parallel, addressing levels of insight and behaviour at the same time but with different approaches.

... There needs to be attention paid to both and not just to treating by counselling ... People feel that the underlying issues are the key, but actually there are two key issues. They are entangled issues. Self-esteem is entangled with issues about eating, so you can’t address one without addressing the other.

Clinical Psychologist NHS 025 185-189

The practitioner using predominantly CBT felt that it was suitable for clients with a wide range of conditions and that it seemed to be particularly popular with those who were students, seeing it as compatible with other forms of psychotherapy and medication (Appendix 5.3.2.d).

5.4 Students' use of other agencies

People with mental health problems in Oxford sometimes made direct contact with community-based voluntary sector agencies, whilst others were referred by health and social services. Students did not seem to use these agencies to any great extent, nor did students tend to feature amongst the clients of social work agencies¹⁴. Research carried out by the Oxford Student Mental Health Network found that some students contacted help-lines such as those provided by the Samaritans and Mental Health Matters, but were unlikely to use drop-in centres such as those run by MIND (offering a range of activities) or Libra (which provided advice on drug and alcohol issues)¹⁵.

However, some users of voluntary sector agencies in Oxford had aspirations to enter further and higher education (Pitts 2003). Mental health service managers knew that their services also had clients who would benefit from moving into education, but that providing support would be an issue. One manager commented that:

If a CPN [Community Psychiatric Nurse] has 35 cases it is very difficult for them to give the student client extra support. You need people who have time to support them through the system. It doesn't have to be very specialist support, someone to be alongside them but not at a CPN level. The voluntary sector can do this better perhaps? The client may feel more like talking to them.

Mental Health Service Manager NHS 016 49-53

Another service manager felt that local voluntary agencies were good at providing daytime activities for their users but not so capable of helping them to move on into mainstream opportunities (Appendix 5.3.3). Another manager was critical of the services offering support to those affected by substance misuse. This person's comments are particularly significant given the interest in different models of mental health in this research.

Addiction services have no real affinity to any model of treatment. There is no agreement about what really works. This can lead to service providers in-fighting, criticising each other's approaches. There is no real agreement or evidence, there can be contradictory evidence.

Mental Health Service Manager NHS 023 51-54

5.6 Supporting the integration of student patients into academic life

Students with low levels of distress, anxiety and depression had, in principle at least, a choice between seeking and gaining support from friends, academic staff, counsellors or GPs. Apart from some perhaps short-term measures related to the impact

¹⁴ Oxford Student Mental Health Network 2000 *Survey of Service Providers*

¹⁵ OSMHN Report 2003 Student Mental Health in Oxford 2000-2003. See also Oxfordshire Health Promotion 2002 Student Health Improvement Plan.

of their situation on e.g. course work assessment or exams, there was little perceived need for communication about these students between different providers of support. Students with more severe mental health problems were likely to receive medical and/or psychological support or to discontinue their studies. Some form of collaboration between healthcare providers and members of staff in educational institutions was often seen as potentially helpful, if not always easy to arrange when such students returned to study after a period of treatment, or continued to study during treatment. The same was true to some extent for students entering further and higher education with existing mental health problems.

Chapter 4 examined the support available to such students within their educational institutions. The previous sections of this Chapter have explored the nature of treatment and support offered to students by health services. This section considers the issues raised when staff and students in healthcare and educational institutions identified the need to work and communicate across their organisational boundaries. The key issues raised by research respondents are summarised in Table 5.10 below.

Table 5.10 Actions benefiting from collaboration between healthcare and educational institutions¹⁶

Assessing the student's fitness to return to/take up a place in a college or university
Identifying the student's wishes for the sharing of information
Facilitating re-entry/entry to academic life
Finding suitable residential accommodation
Negotiating time-out from studies
Reducing the pace of academic work
Managing the stress of exams
Dealing with the stigma/embarrassment of receiving a mental illness diagnosis
Avoiding abuse of alcohol and illicit drugs
Identifying the symptoms of relapse or deterioration in mental health
Reducing the risk of suicide
Managing challenging behaviour
Knowing when to make an intervention
Identifying sources of appropriate ongoing support
Enlisting the support of personal tutors
Dealing with the reactions of other students

¹⁶ Based on research interviews 2000-2003

Whilst the main focus of staff working in secondary and tertiary mental healthcare was treatment of the student's mental health condition, many were aware that the student would also have to cope with going back into an academic environment. However, they did not have established procedures or links for communicating with staff in the local colleges and universities to facilitate this process, and they lacked knowledge of the relevant policies within the local colleges and universities for dealing with students' leave of absence from their studies (Appendix 5.3.4.a).

You would need to get contact details for each institution. At Oxford University you will be passed from one department to another. We have had occasions where there has been no contact with the university, maybe the student wouldn't want it.

Psychiatric Nurse NHS 026 109-112

The main exception to this lack of communication was the Head of Student Services at Oxford Brookes University, who was extremely proactive in making contact with mental health departments and units treating students from that university. Many staff commented on how helpful contact with this individual had been (Appendix 5.3.4.a), but this was a case of communication relying on an individual's efforts and personality rather than being built into a system. Five of the respondents from mental health services suggested that collaboration could be improved by taking a more systematic approach. Their ideas included the extension and development of a student mental health network building on the work of the Oxford Student Mental Health Network, employing a 'student mental health champion' and designating key staff in healthcare and education to act as student mental health link persons (Appendix 5.3.4.b).

It is important that networks are in place. Not just those who express an interest but the key people in place. The CMHT managers will be essential, although there are only two of those in the city. Knowing that a student mental health network is there will keep people interested. There is a need to encourage the others that should be involved, but link it to posts and not personalities.

Mental Health Service Manager NHS 014 129-133

If something is built into the culture, if it is a useful tool, it would be carried on ...

It could not rely on yet another piece of paper coming round, it doesn't sink in. In my experience developing closer links, having a face to match the name and developing rapport is more effective.

Psychiatric Nurse NHS 026 118-126

The development of these formalised channels of communication was considered important in order to carry out the actions described in Table 5.10, and was also seen as a way of developing treatment services which could take the needs of the local student population more fully into account.

One example of a tool that could be used to support a patient's pathway back into education was the Care Programme Approach, designed for those with severe mental illness and mandatory for them. This offered the opportunity to identify and record an individual's needs and sources of ongoing support upon discharge from intensive treatment. However, in this research the CPA was not found to be used for students who were going back to their studies or entering further/higher education for the first time:

Discussion of involving someone in the university or college wouldn't happen routinely in the CPA [Care Programme Approach] discharge plan.

Psychiatric Nurse NHS 026 105

Part of the reason for the lack of collaborative planning was that it did not occur to healthcare staff, who were more focused on issues such as medication and follow-up treatment than how the student would be supported in an academic environment. Another factor was concern about confidentiality when communicating with individuals outside of health and social work agencies (Appendix 5.3.4.c). Healthcare staff were clear that students' consent to the sharing of personal information was essential in all but the most extreme cases, but even with that consent in place some had concerns about sharing such information with people who were not health or social work professionals:

Brookes do seem very aware of people being vulnerable and to be good at supporting them. Those who have used our service certainly need to be followed up by us. If there was to be collaboration with the academic institution it would be important how confidentiality is managed. We could ask if staff want to keep us in touch whether it is for crises or for blips. Would it help university staff to have input from our service on the signs and symptoms of mental illness?

Psychiatric Nurse NHS 015 126-131

Healthcare staff were prepared to help raise the mental health awareness of staff working in colleges and universities and to receive information about particular students from them, but were more cautious and restricted in their ability to discuss a individual student's needs with these social supporters:

If there are particular risks, then there would be a need to share information with residential or academic staff, but confidentiality considerations normally prevent information sharing. However, what could be done is helping such staff to cope by providing general education in mental health issues. You can say in general what they should be doing without mentioning individuals. Often that general information is useful.

Mental Health Service Manager NHS 016 73-78

If greater collaboration between mental healthcare providers and educational institutions could be developed, healthcare staff could see many potential benefits for student patients. They felt that collaboration from them could help staff

working in academic institutions to recognise emerging mental health problems in order that they could encourage referral at an appropriately early stage. They also felt that staff in academic institutions could be helped to respond to the students in an appropriate way:

I would want to warn residential staff and others to look out for the conversations with the student that go along the lines of 'I don't want you to tell anyone else this but ...'. It could happen to a Hall Warden, and we get it and we say we must share in our team. It is about not colluding with them, and recognising that it could be time for treatment to be required.

Psychiatric Nurse NHS 015 140-149

Some healthcare staff were concerned that social supporters e.g. fellow students, academics and residential staff, would attempt to contain students with quite serious mental health problems for too long. Educating these social supporters in order to firm up their boundaries and raise their awareness of the medical symptoms of mental health conditions was seen as a means to earlier referral to professional services. Medical and psychological practitioners had ideas about the role social supporters could play in enabling access to mental health services, but less were certain about how such supporters could contribute to the students' pathways back into academic life.

The need to negotiate practical issues, such as where the student was going to live and how they could take time out from their studies, was commonly recognised. Other issues to do with social integration, dealing with stigma and discrimination or managing the process of academic study were acknowledged by some staff in mental health services (Appendix 5.3.4.a), but they did not have service-wide systems in place for addressing this social level of need:

It would be helpful to have closer contact with colleges and to have accessibility. It would be useful to meet people like tutors to see what support networks are in place. There are occasions when we do need to make contact ... Then we can know what support is available and gradually reintegrate the student.

Psychiatric Nurse NHS 026 104-108

The value of the contacts made by the Head of Student Services at Oxford Brookes University has already been mentioned. The existence of a centralised student support system at this university made for simpler channels of communication. By contrast, the collegiate system at the University of Oxford made finding the right person to contact more difficult. Some of the mental healthcare staff interviewed (Appendices 5.3.4.d & 5.3.4.e) had also found that tutors and other staff in the individual colleges varied in their ability and willingness to offer support:

There are issues of how colleges respond. A student at one college had a hard time as she was perceived as having a bad effect on fellow students, raising their anxiety. She wanted to use the library in her year out and visit friends. The college authorities didn't want her to visit the college, they may have their reasons. That did worry me, but she got a lot of support, particularly from the College Secretary, and you don't know who will be helpful. Some tutors can be helpful, some show a complete lack of awareness.

Clinical Psychologist NHS 025 165-170

Fellow students have been seen to play a key role in supporting students with varying levels of mental health problems (Chapter 4). However, the nature of their role in supporting the re-integration of students returning from treatment for serious mental health problems has not been formally recognised:

Students' friends do a lot of work in containing people in the community and they are not getting a care allowance for doing so! So friends are very important ...

The peer support scheme is very good, very strong. Students will say they have been contained in that system.

Clinical Psychologist NHS 020 149-150, 154-155

Most of the mental health staff interviewed did not show an awareness of the role that fellow students could play in providing social support. Similarly none mentioned any contact with either of the universities' disability advisers. Apart from contact with the Head of Student Services at Brookes and some tutors in the universities and local colleges, the other source of support they were most aware of was the university counselling services.

The interview responses indicated a lack of clarity about the appropriate use of the psychological support offered by university counselling services. There were different opinions about whether or not it was appropriate to ask these services to provide ongoing support for students following psychiatric treatment, and in some cases ambivalent attitudes to the approaches adopted by counsellors (Appendix 5.3.4.f).

Students have a good counselling service compared to the rest of the population but they do need a psychiatrist to go in and see those with serious mental health issues quickly.

The counsellors are good but what do they offer? The professionalisation of counselling is in danger of decrying what others offer e.g. chaplains, tutors, and GPs. It [university counselling] is psychoanalysis not counselling and surely must take a long time.

Psychiatrist NHS 001 127-132

Some GPs were involved in getting support for students at their university or college, once these students were referred back to primary care after treatment by the mental health services (section 5.2.4 of this Chapter). Their relationship with university counselling services was also equivocal (Appendix 5.2.4). At the University of Oxford, college nurses could also become involved in ongoing support (Chapter 4 section 4.2.6).

This worked well in some cases and less so in others (Appendix 4.2.7).

There are instances of college nurses becoming over-involved, showing a need for more college nurse training. It is quite worrying what they are doing, potentially undermining the therapeutic work, fostering a dependent relationship.

Clinical Psychologist NHS 020 150-153

Mental health services, although not strongly focused on the task of re-integrating student patients into their academic environment, in some instances encouraged a transitional and gradual approach to going back to study (Appendix 5.3.4.g). Hospital wards were open to certain students going to lectures in the day and returning to their wards for the night. One of the nurses felt that hospitals could act as a sanctuary from the stress of academic life. However, a psychiatrist commented that wards were not the best places to be and that some form of sheltered accommodation might be more suitable for students who needed to be away from their previous residence.

Returning to a hall of residence, shared house or college accommodation after a period of treatment for mental health problems was not always straightforward. The stigma of having been in hospital would mark a person out as different, according to one student representative. Other respondents referred to difficulties caused when the student's behaviour prior to treatment had disturbed others in their community. In some cases students had lost their accommodation as a result of their behaviour (Appendices 4.1.3, 5.3.4.a & 5.3.4.c).

Health service managers and the psychiatrists working with adolescent clients saw entry to further and higher education as part of the recovery process for some service users (Appendix 5.3.4.h). One manager commented that younger clients needed something more than rehabilitation services which just helped them to fill their days. Another manager felt that further education was less pressured and hence more suitable than higher education for many adults with serious mental illness. An assertive outreach approach was seen as desirable, taking the support to where the individual was based. The nurse/counsellor at the Further Education college, a former psychiatric nurse, was mentioned by two respondents as an example of someone who demonstrated good practice by providing support where it was needed:

WW [named individual] did a good job in building relationships and working alongside the Assertive Outreach Team, and there was lots of communication and letting people know if there were any problems and making sure that he [the student] was getting support. That level of support from a tutor in further education would be unlikely because of the numbers in classes, and because it is complicated to understand mental health services from the outside.

Mental Health Service Manager NHS 023 91-96

5.7 Views on the quality of mental health services for students

A huge issue for many students is when it is agreed that NHS psychological or psychiatric treatment would be the best outcome, but due to the grotesquely impoverished resources, such treatment is not available.

Counsellor OXB 007 152-154

Those interviewed in the healthcare and academic sectors seemed to be most concerned with the difficulty of accessing mental health services. There were apprehensions that a few services and practitioners were too medically focused in their approach. There were fewer worries about the quality of support offered to those who did receive treatment, but a number of respondents felt that there was a lack of appropriate support for student patients after discharge (Appendices 5.3.4.f & 5.3.5). This shortfall in ongoing support put pressure on university counselling services, student services and residential staff. In some cases it was seen as contributing to the students' withdrawal from their studies.

One respondent felt that the quality of support for students would be improved if the division between primary and secondary care services could be addressed.

Community Mental Health Teams and CPNs come under the Mental Health service so it isn't possible to work as a team with the primary care service. A one stop shop would be ideal. There is no reason why it couldn't happen as we have a counsellor, psychologist and CPN in the same building. There is no reason why they shouldn't work together but for the fact that they work for different employers.

General Practitioner NHS 004 200-205

More generally, ideas for developing good channels of communication and linking up different sources of support, covered earlier in this chapter, form a key theme in the consideration of the quality of service provision for students. The comments of those interviewed suggest that the ability to move between social, psychological and medical sources of support at an appropriate time is crucial to improving the likelihood that students with mental health problems complete their studies successfully.

5.8 Summary

Health service support was only accessed by a proportion of the students with mental health problems. Those with more severe problems were more likely to receive medical support than those affected by stress, anxiety and low levels of depression. In some cases students accessed healthcare services directly, in others they were referred because other people were concerned about the perceived risk they posed to themselves

or those around them.

Primary care services provided medical support and limited access to counselling support for students. General Practitioners were the main point of access, or gateway, to secondary mental health services. These GPs varied in the extent to which they viewed psychological or pharmacological interventions as appropriate for common mental health problems. Where psychological interventions were favoured, Cognitive Behavioural Therapy was preferred rather than the psychodynamic approach. Primary care practitioners encountering patients with probable psychotic problems invariably regarded these as requiring medical intervention and made referral for psychiatric assessment. The GPs interviewed were aware that their student patients were affected by social factors and needed support at a social level, but often these needs had to be met by others, due to time constraints and the boundaries of their role.

GPs working with students at the University of Oxford were more closely identified with that institution than were those associated with Oxford Brookes University. There were both positive and negative aspects to this in that they could engage support from tutors, college nurses and others where the relationship was strong, but students feared that sensitive information might be fed back to their institution. Respondents had quite mixed views on the quality of primary care services available, ranging from very positive about accessibility and fast responses, to negative comments and frustration about lack of response and poor communication.

The services provided by the local mental healthcare trust encompassed psychological and medical approaches to mental health. Community Mental Health Teams were interdisciplinary but there were no reported cases of students receiving support from social workers. Psychological treatment was limited by resource considerations and it was reported that only one in six of the patients who could benefit were able to receive psychological therapy. Psychiatrists by the nature of their role followed established medical procedures in their work with students, but could also refer them for psychological support, and were aware of the impact of social factors on their patients' mental health. The psychiatrists interviewed preferred to refer patients for Cognitive Behavioural Therapy and some of them were dubious of the value of psychodynamic approaches. The hospital-based psychiatric nurses interviewed were able to take on a more holistic role and distinguished that from the medical approach taken by hospital doctors.

Tertiary mental health services had a strong psychological/psychotherapeutic element. Cognitive Behavioural Therapy was used widely and Cognitive Analytic

Therapy was used to a lesser extent. None of the practitioners interviewed used a psychodynamic/psychoanalytic approach. There was an ongoing debate within the service about the value of medical versus psychological interventions, but most respondents felt that both had a valid role to play. All of the respondents at this level identified social needs among their student patients and the desirability of working with educational institutions in order to meet them.

Mental health service managers were particularly aware of service users who were not yet students but who might benefit from participation, particularly in further education. This was seen as a potential pathway back to a more integrated social role in the local community.

Lack of resources in the NHS provision of psychological services were reported as having negative consequences for students. Respondents from all sectors made the point that students with serious, but not psychotic, problems found it difficult to access secondary and tertiary services within the time that they were at college or university. Some of these students were given limited support by university counsellors or GPs, who felt dissatisfied that they were not able to give the students the depth and quality of treatment they deserved.

Although there was a desire to promote a more integrated approach between the providers of social, psychological and medical support, the sharing of information about student patients was a contentious issue. There were no clear and consistent procedures on the use of sensitive information. Staff felt constrained by professional codes of conduct as well as by doubts about the safety of sharing information beyond the boundaries of their own service. Nevertheless, a significant proportion of the staff interviewed were willing to explore ways of developing greater collaboration between the academic and healthcare sectors.

Chapter 6 Discussion: Social, Psychological and Medical Approaches to Students' Mental Health

This research took as its starting point Tyrer and Steinberg's (1999) models of mental disorder (their terminology) and attempted to apply them to the mental health of the student population in Oxford. This population appeared to experience high levels of stress, anxiety and depression and to a lesser extent more severe mental health conditions (e.g. schizophrenia, bi-polar affective disorder, eating disorders, attempted suicide, self-harm and substance misuse). The support offered to students could thus be explored in depth, knowing the range and potential severity of their problems. In this chapter social, psychological and medical approaches to mental health are reconsidered in the light of the research findings. An integrative model is explored and recommendations based on the case studies are suggested.

6.1 Modelling mental health

Tyrer and Steinberg (1999) distinguished between social, psychodynamic, cognitive, behavioural and biological (or disease) models of mental health. They also suggested a conceptual framework that could be used within psychiatry to provide an understanding of mental health problems and to plan an integrated approach to their treatment, using each of the above approaches. This attempt to combine different approaches differed from a number of other writers who sought to promote one or more approaches as being more appropriate than others.

For this research I adapted Tyrer and Steinberg's framework, extending it beyond the field of psychiatry to a much wider network of support and treatment. I also reduced their five models to three main headings of social, psychological and medical approaches to mental health. Within this research, cognitive and behavioural approaches were found to be often combined within the CBT framework; psychodynamic approaches were commonly encountered, as were others not mentioned by the authors such as a person-centred approach and solution-focused therapy. For simplicity I adopted a broad category of psychological approaches, whilst commenting on the differences between them when appropriate.

Tyrer and Steinberg referred to a disease or biological model, distinguishing it from a medical model, because they saw the latter as being concerned with diagnosis, identification of causes and recommendation of suitable treatments based on any of the five models in their framework.

The pedigree of the 'medical model' is not to be found in the annals of discovery about the physical origins and treatment of disease, but in the nature of the doctor-patient relationship.

(Tyrer & Steinberg 1999, 111)

As this research was concerned with the provision of support and exploration of individual roles within the organisations studied, use of the term 'medical' seemed more appropriate. Talk of 'biological' support or 'disease' support does not fit with descriptions of particular roles. In using the term 'medical' to describe a particular approach to support I have not assumed that this is synonymous with a purely biological approach. The medical approach is informed by biological science but is mainly distinguished by its focus on diagnosis and treatment of specific conditions.

An underpinning expectation of this research was that people with mental health problems would have needs which could be usefully addressed at different levels (social, psychological and medical), whilst responses to these needs within different organisations might be determined by adherence to particular models of mental health. In practice what distinguished the three educational institutions and two healthcare trusts studied from each other was not their adherence to formal models of mental health, whether social, psychological or medical, but their ability to offer support at each of these levels. The individual practitioners and also non-professional individuals who provided support to students evaluated social, psychological and medical interventions differently. For example, some GPs were more medically-oriented to mental health issues than others. However, the debate on the nature of mental health was not as polarised on the ground as in the literature and most of those interviewed took a fairly holistic view.

6.1.1 The nature of mental health problems

There was common agreement amongst the research respondents that there were such things as mental health problems and that students experiencing them could be identified by their behaviour, feelings, thoughts and experiences (Chapter 3). Respondents rarely offered explicit definitions of mental health problems, and they varied in the language they used to describe them. Some would initially focus on the more dramatic presentations, often associated with psychoses, which had come to their attention. However, many gave examples of a whole range of mental health problems encountered, including the more common conditions of anxiety and depression. In common with other work which has looked at lay knowledge and understanding of mental health (Rogers & Pilgrim 1997), one of the key indicators was not so much

whether a person was happy or sad, but whether they could cope with the demands of their everyday life.

Some respondents distinguished between the symptoms of stress, which were seen as understandable given the pressures that students were under, and those of mental ill-health which were typically seen as indicative of some underlying problem which the student had brought with them to the situation. Some writers have suggested that ultimately it is health professionals who decide who does and who does not have a mental health problem (e.g. Goldberg & Huxley 1992). Whilst at a formal diagnostic level this was true, in many cases other people who were in contact with disturbed students had already formed an opinion about their mental state and were looking to the health professional not so much to confirm it, but to produce a formulation of the problem that would enable access to treatment services.

6.1.2 Views on the causes of mental health problems

There was a wide range of views on the causes of mental health problems. Many respondents mentioned multiple factors to do with vulnerability, stress and coping. There were no obvious divisions in the ideas of causation between those respondents in medical, psychological and social roles. Most took a holistic approach, with some factors more to the fore than others. Although they did not categorise them, the possible causes they cited could be fitted into the categories suggested by writers on models of mental health and different psychological approaches (e.g. Carr 2001). Examples of predisposing vulnerability factors mentioned ranged from family experiences, exposure to traumatic events, personality aspects and problems with emotional and skills development to genetic factors and abnormal brain biology. Many stressors were cited including: academic work, student lifestyles, economic pressures, family issues, isolation, rivalry, and drug and alcohol use (Chapter 3).

Despite this commonality of views, most respondents worked exclusively within specific roles using social, psychological or medical interventions. Whereas some of the literature (e.g. Read et al. 2004) suggests that a particular approach or model should be adopted as explaining mental health problems and providing the best treatment, this research suggests that in practice many individuals may offer one form of support whilst also accepting the validity of other approaches. It is from this focus on role rather than philosophy that the different approaches to supporting students are explored in this chapter.

6.1.3 Students seeking and receiving help from social, psychological and medical sources

There is a stigma attached to seeking help for mental health problems which can hinder students' access to support and treatment services (Stanley & Manthorpe 2001). Some students in Oxford were reluctant to seek any help at all, causing concern to fellow students and staff (Chapters 3 & 4). Students are more likely to seek help for anxiety and stress from friends, family and academic staff than from counsellors or GPs (Grant 2002). Such findings have been strongly supported by this research, which found high levels of social support for common mental health problems combined with fears of the consequences of accessing counselling or medical support (Chapter 3). Students feared being told that they were going 'mad' and that something going on their 'records' might become known by others in their educational institution or affect their career prospects. These could be seen as legitimate fears, particularly in relation to any medical diagnoses which might have to be declared on job application forms. They were also worried that use of counselling services would lead to similar problems, although in fact this was unlikely to have been the case.

Respondents believed that some students, whilst aware of their emotional or mental health problems, avoided facing up to their situation by throwing themselves into academic and other activities, refusing to talk about their problems, or using other unsuccessful strategies such as abusing drugs and alcohol (Chapter 3). In the wider community, some people with the more serious levels of neurotic disorders were found to be the most reluctant to seek formal help (Meltzer et al. 2000). Respondents reported similar situations amongst the student population of Oxford.

Students with other severe mental health conditions such as schizophrenia, bipolar disorder, eating disorders and self-harm were seen as the least likely to either acknowledge their problems or to seek any form of help. In these cases they were likely to be pushed by others towards accessing medical support as their behaviour became increasingly disturbing for those around them.

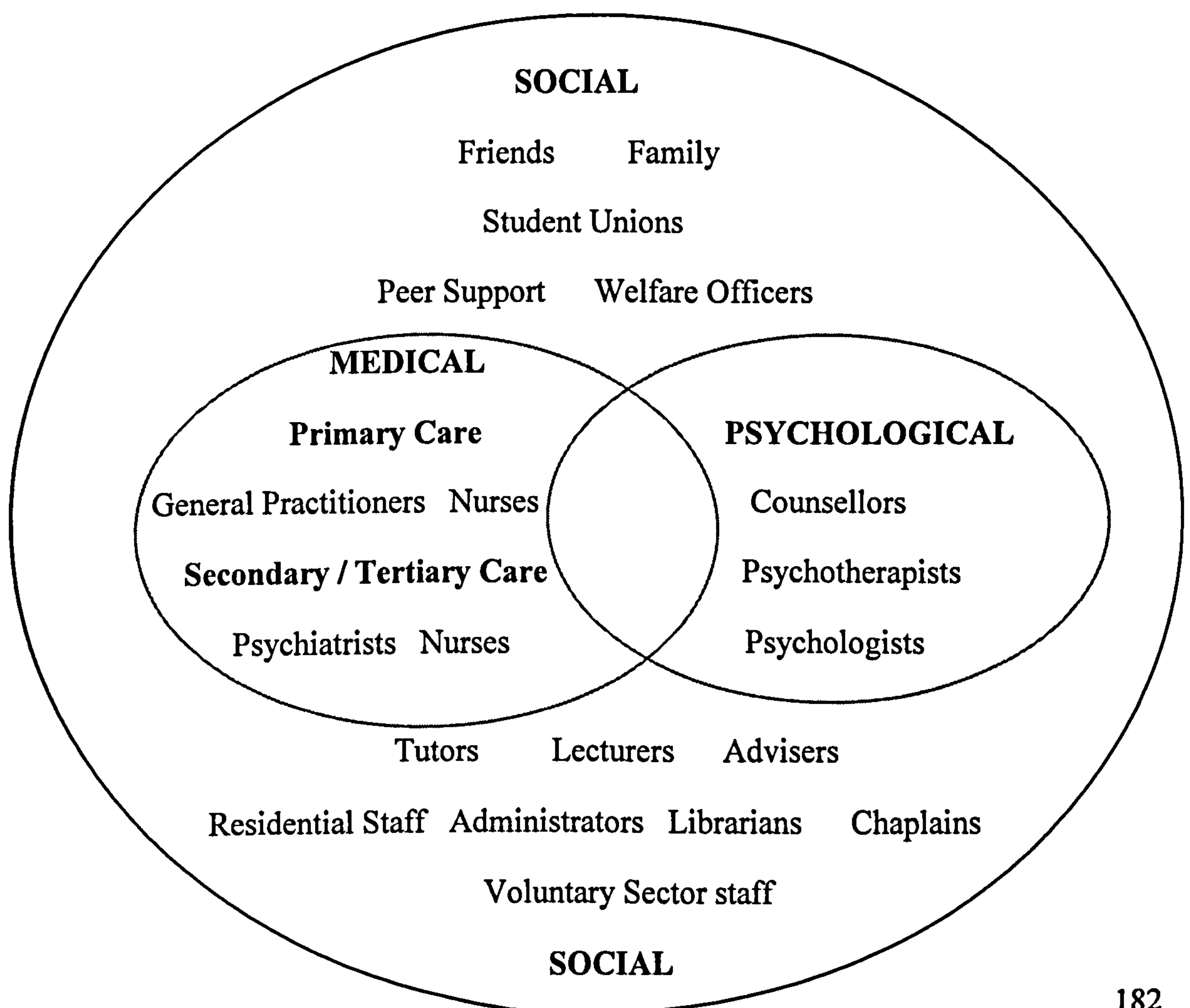
Students experiencing stress and anxiety used some coping strategies that were felt to be reasonably successful including engaging in sports and other physical activities, and using meditation and relaxation techniques (Chapter 3). In this they were found to take a similar approach to members of the general population who tend to identify social causes of stress but to apply individual solutions to their problems (Rogers & Pilgrim 1997). Counsellors in particular reported that students using their service for the first time had often tried a range of self-help strategies, seeking professional help when their situation failed to improve or deteriorated. In the general

population (Jorm 2000) self-help and psychological support tend to be favoured over medical treatments. This was mirrored in the research findings with students to some extent, but any professional intervention, whether psychological or medical, tended to be seen as a last resort.

Students on certain vocational courses were also affected by considerations of their present and future fitness to practice. The requirements of medical, social work and nursing bodies have to be taken into account when a student has a history of severe mental health problems (Manthorpe & Stanley 1999a). In this research, respondents had concerns about social work students and nursing students who worked with mental health services on clinical placements but could find themselves becoming service users (Chapter 5). In contrast occupational therapy teaching staff were quite accepting of students with mental health problems and looked at ways that their personal experience of coping could inform their practice.

When students sought social, psychological or medical support they had the option of approaching a range of people, some in formal roles and others who had a more informal position. Examples of these sources of support are given in Figure 6.1 below.

Figure 6.1 Sources of the support available to students with mental and emotional health problems



The overlap between the medical and psychological categories reflects the finding that some medical practitioners also used structured psychological interventions. The inclusion of the medical and psychological categories within the social sphere acknowledges that all interventions take place within a social context. Many of these sources of support have already been identified by other researchers (e.g. Stanley & Manthorpe 2001). This research went further in exploring in detail the nature of the support offered and the relationships between different providers of that support.

6.2 Social approaches to mental health revisited

A sociological perspective (Pilgrim & Rogers 1999) indicates that students will be affected by their social and economic position and that particular groups will have their own distinctive problems and needs which should be targeted. Another sociological view (Furedi 2004) points to the danger of individualising the impact of negative social forces as this can encourage a 'therapy culture' rather than political and social action. Models developed by the disability movement (Barnes & Shardlow 1996) highlight the importance of identifying disabling practices and discriminatory attitudes which exist in universities, colleges and support services. The bio-social model (Goldberg & Huxley 1992) points to the social factors that make individual students vulnerable and which act as stressors upon their mental health. A social support model (Milne 1999) invites exploration of social factors which can buffer students against developing mental health problems and those which can aid their recovery.

None of the research respondents expressed the radical social model view that mental health problems are socially constructed, equating diagnosis with a means of exerting social control by labelling deviant behaviour (Beresford 2002). There was general acceptance that mental health problems exist, even if there were varying views on what conditions or experiences would be included under that heading.

6.2.1 Views on social causes of mental health problems

Many respondents identified social and social-psychological factors which affected the mental health of students (Chapter 3). These factors were not made explicit as a conceptual model, but were implicitly acknowledged when identifying the causes or triggers of mental health problems. The move from home, debt, academic pressures and other social factors have been cited in the literature as stressors on students. This

research project has confirmed that such issues, and others such as students' lifestyles, were seen to have a significant impact both by students and those who supported them.

A typical view, especially amongst residential staff, was that an increasing number of students were experiencing mental health problems. This situation has been reported more widely across the UK (Rana et al. 1999) where it was seen partly as a reflection of widening participation and the corresponding change in the nature of the student population. Social issues such as economic pressures, family difficulties, academic work and the culture of binge drinking and drug use were commonly cited by respondents as contributing to the deterioration of the student population's mental health and well-being (Chapter 3). Surveys of student populations have similarly identified economic factors (Roberts et al. 2000), drug and alcohol use (Webb et al. 1996), exam stress (Surtees et al. 2000) and other academic pressures (Tyrell 1992) as having a negative impact.

Students and those who provided support to them were clear that students were distinguished by their lifestyles and the nature of the academic year from other members of the local population. Therefore, studies which focus mainly on the issues facing young people in transition to adulthood (Jacobson 2002) may only provide part of the picture. Transition was felt to be only one of the many pressures facing the students. Respondents commented on the pressures on students to achieve high grades whilst having to deal with debt and in many cases managing a part-time job. These were all issues that could be treated at the level of individual psychological distress or could be seen as needing a broader social and political approach (Furedi 2004). As only around 3% of the student population (Chapter 4) were attending counselling services, and residential staff reported that it was very difficult to persuade troubled students to see a counsellor (Chapter 3), fears of an excessive therapy culture would seem to be premature.

Earwaker (1992) is one of the few writers to have considered the consequences of institutional structures for students' mental health. Locally there were many comments from respondents which indicated how academic institutions had both positive and negative impacts on the well-being of their student populations (Chapter 3). Higher and further education, together with the associated opportunities for sporting, cultural and social activities were seen as having a positive effect for many students. However, the way these institutions were organised and the attitudes and behaviour of some of the people within them were sometimes felt to have a damaging effect.

At the University of Oxford in particular some students were affected by fellow students' high levels of achievement and the competitive atmosphere in the close-knit

college environment. Also widely reported was the feeling of being an intellectual fraud who would soon be caught out, and of moving from being top of the class at school to being a 'small fish in a big pool' at university. In contrast, some students at Oxford Brookes University were likely to be adversely affected by the size and anonymity of the organisation. In both cases some students felt that they didn't fit in and were less able to develop effective social support networks. Post-graduate students were felt to be particularly vulnerable to feelings of isolation, loneliness and self-doubt which affected their mental health.

Such views shift the focus from the individual and personal aspects of mental health towards a broader consideration of social structures and how these might have a negative effect on well-being and present disabling barriers to certain students. The concept of disabling barriers has been developed further in the field of physical and sensory impairments than it has in mental health (Oliver 1990). However, the inclusion of recognised mental health conditions within the UK's Disability Discrimination Act (1995) has forced employers, and more recently education providers, to think about their organisations' practices and procedures (DRC 2002). Staff attitudes, study patterns, exams and assessments, requirement to take time out and residential problems were amongst the issues raised by respondents as potential barriers to students with mental health problems.

6.2.2 Social support for students

Social support can be viewed as a preventative or buffering factor enabling people to maintain positive mental health (Milne 1999). People can experience and be aware of distress without requiring psychological or medical interventions, instead dealing with it through social interactions or individual coping mechanisms. In this research, students were described as using a range of coping strategies to deal with distress, not all of which were successful (Chapter 3). Students relied on their fellow students and friends a great deal for day-to-day support with their anxieties and stresses. Welfare representatives and staff members also provided support at this level (Chapter 4).

Social support can also help with recovery and re-integration following treatment for serious mental health problems (Milne 1999). Students returning from treatment had to deal with the resulting stigma and the isolation that could follow a major mental health episode, as well as working out the best ways to resume their studies. Although some students in this position benefited from the individual efforts of student services, tutorial or residential staff, there was no explicit organised system to

ensure that appropriate social support was in place (Chapter 5). Some students were reported to have met with distancing or dismissive responses, whereas others experienced over-protective or 'smothering' responses. There was a similar lack of consistent social support for those entering further or higher education for the first time (Pitts 2003).

Many examples of social support were encountered, especially when students experienced stress, emotional distress, anxiety and depression (Chapter 4). Despite being so common, or perhaps because of it, social interventions are often less structured and definable than psychological or medical ones. Milne (1999) has studied the nature of the social support given by friends and others encountered informally (e.g. hairdressers) specifically in relation to mental health. He suggests that the main components comprise: emotional support, companionship, practical assistance and informational guidance. This is consistent with descriptions of the support given by fellow students, academic and residential staff to students in Oxford (Chapter 4).

Whilst social support is important in promoting good mental health (Harrison 1999) and may act as a buffer to prevent relapse into mental illness (Milne 1999), there are also difficulties associated with it. Milne suggests that the giver risks emotional overload and verbal abuse, and may make the situation worse by pushing the person into accessing professional help rather than attempting to normalise their problems. The recipient of support may feel pressured to get better, find that their confidences have been betrayed, or have their situation made worse by being offered unsuitable strategies such as trying to ignore the problem and alcohol use. Milne also casts doubt on the value of support which just allows the expression of emotions, quoting research which found better outcomes for people with depression when they used problem-solving techniques rather than emotional discharge.

In Oxford there were similar indications of less positive aspects (Chapter 4). Some students felt overwhelmed by the needs of their distressed friends. Confidentiality was a major concern, as was the desire to promote a positive front, leading some students to seek social support outside of their immediate circle of acquaintances. Although social supporters sometimes encouraged students to access professional help, this was more likely to be achieved by increasing their awareness of the options available and helping to overcome the stigma of approaching services, than by putting them under pressure as Milne suggests. In fact counsellors and healthcare professionals sometimes felt that students had been maintained by social support for too long, delaying their access to services which might have been more effective earlier.

One of the main roles of the trained peer supporters at the University of Oxford was to facilitate entry to professional support services (Chapter 4).

Social support came from a wider group than family, friends and fellow students. Academic, administrative and residential staff in the universities and colleges also played a significant role (Chapter 4). Sometimes this was due to their position which gave them pastoral responsibilities for students, but in others they were sought out because of their personalities and perceived approachability. Staff were more likely to set boundaries to their involvement than were students. The nature of their support was similar but was more focused on finding solutions to practical problems and helping the student to access other sources of support.

The majority of the social support that has been mentioned so far has been that which was given to students who remained within their academic institution whilst experiencing emotional and mental health problems. Another smaller category of students included those who experienced such severe problems that they had to take time away from the college or university, possibly including a period of intensive hospital-based treatment. In some cases these students had been previously experienced as disturbing, disruptive or frightening by those around them (Chapter 3). The return of these students was faced with apprehension and it was not clear what level of social support they could expect to receive. Residential staff and tutors would not necessarily receive any information about the student's progress since leaving for psychiatric treatment and did not feel equipped to provide appropriate support (Chapter 4). Some of these staff felt the need for somebody who could offer that support or make the necessary linkages in a professional role.

With the exception of social workers, who tended not to become involved with students in Oxford, the closest to a professional social support role was that of the adviser. These could take the form of disability, welfare, advice or specialist student advisers. All of these encountered student with mental health problems, although it was only the disability staff who had a specific remit to provide ongoing support and advice for such students (Chapter 4). The role of the adviser has not been covered in any depth in the literature on student mental health and yet these staff played a crucial role in helping students with the complexities and disabling barriers encountered in their academic institutions. Although it was not the case in Oxford during the research period, an increasing number of further and higher education institutions were employing specialist mental health support workers who took on aspects of the advisory role, combined with broader support functions (RCP 2003).

Another group who might benefit from structured social support are mental health service users with long-term support needs. The mental health managers were particularly aware of the needs of this group and saw further education, and to a lesser extent higher education, as a potential pathway to recovery (Chapter 5). Tyrer and Steinberg (1999) identified the integration of service users into normal social roles as one of the key tenets of a social model. This research found examples of students who had taken this pathway, but this often seemed to have been achieved through individual endeavours.

Some implications of this research for a social model of mental health are that social explanations of mental health problems were widespread, but were rarely seen as the only causal factor. Social support was commonly used, especially for anxiety and depression, but where levels of distress or disturbance were high it was not seen as being sufficient in itself. Nevertheless social support was a necessary factor in promoting the well-being of students with mental health problems. Perhaps because social support is not as well structured and articulated as other forms of support, its value and potential was not appreciated to the extent that it deserved.

6.3 Psychological approaches to mental health revisited

Many research respondents offered psychological explanations for the emotional and mental health problems experienced by students. In some cases social and psychological factors would overlap, for example when students experienced distress on leaving home and moving into student accommodation (Chapter 3). The clinical psychologists, psychotherapists and counsellors were not the only interviewees to suggest psychological factors, as there was a lay understanding of these issues amongst many of the students and staff in the educational institutions, and they were identified by medical staff too. Not surprisingly those working as psychologists, psychotherapists and counsellors had the most clearly defined psychological models of mental health. Others tended to refer to psychological issues without placing them in a broader theoretical context and did not mention the more complex factors such as subconscious feelings, transference and counter-transference, of which many of the counsellors seemed particularly aware.

6.3.1 Psychological causes of mental health problems

Researchers and writers (Chapter 1) have investigated many psychological issues which make students vulnerable to mental health problems: earlier family experiences, personality factors, home-sickness, internal identity conflicts, developmental and transitional problems. Examples of all of these were given by the research respondents in this study but many also mentioned the intensity of student life. Students' lifestyles were described as unbalanced with not enough time for relaxation and with too little contact with 'ordinary life'. Although the atmosphere at the University of Oxford was described as particularly pressured, students at Oxford Brookes University were also seen as being very stressed. This intensity was viewed as psychologically unhealthy, impacting on those who were already vulnerable and reinforcing the effects of other stressors on students.

Transitional issues were encountered and were not confined to the younger students. Many were older than the typical 18-21 age group, especially at Oxford Brookes University. Post-graduate students made up over a quarter of the local student population (Chapter 3). There were also younger students at the college of further education, most of whom were still living at home. Apter's (2001) suggestion that the age of achieving emotional maturity and independence has risen is consistent with the views of local respondents who found anxieties and insecurities amongst students of all ages. Residential staff noted immature behaviour and other reactions to new-found freedom from parental constraints amongst younger students, whilst some counsellors remarked that even mature students could be thrown into a state of uncertainty, similar to earlier transitional stages, by the experience of entering higher education (Chapter 3).

6.3.2 Psychological support for students

In this research certain approaches to support have been grouped under the heading of 'psychological'. Tyrer and Steinberg's (1999) integrative model placed psychodynamic, cognitive and behavioural interventions between social and biological (or medical) ones. Each of these psychological approaches was seen as having a place in treating different levels of mental disorder. In this research it was not possible to test the validity of this claim. However, there were psychological practitioners who referred to the value of being able to switch between different psychotherapeutic approaches in order to deal with different aspect of their clients' problems. Others preferred to keep to one approach, seeing it as sufficient in itself. What was clear was that psychological support of some sort was commonly seen as necessary.

Students within the institutions studied had psychological needs which social supporters sometimes did not feel they could meet, given the emotional content and feelings provoked. Milne (1999) has suggested that there are limitations to what social support can achieve, and this was reflected in the actions of students' friends who were often influential in persuading them to seek psychological support when those friends felt that they could be of no further help (Chapter 3). Sometimes the students wanted the anonymity of the counselling relationship so that they could present a positive front to their friends and others around them. External support was sometimes needed when the person needed to move beyond expressing their emotions to making changes in how they felt, thought and behaved (Chapter 4). Counsellors felt that students benefited from time and space away from the hectic pace of their academic and social lives to make sense of their experiences and feelings. Students had a number of unsuccessful coping strategies, often connected to their lifestyles (Chapter 3), and individual work with a counsellor or psychotherapist was seen as a way of helping them develop more constructive strategies.

One rationale for the provision of counselling services within educational institutions is the need to support students experiencing emotional and psychological difficulties which might affect their studies and their ability to participate in student life (Bell 1996). Some of these difficulties are probably linked to developmental stages and transitions into adulthood associated with the typical age-group of undergraduates. The counsellors interviewed confirmed that they saw their main role as supporting the educational progress of their clients. In addition they encountered students with a wide range of mental health problems, some of which they felt able to address e.g. low levels of anxiety and depression, and others which they needed to refer on e.g. psychoses, severe depression and obsessive-compulsive disorders. In some cases counsellors were willing to continue working with students who had severe levels of mental illness provided that the student was also getting medical support. Some counsellors felt able to work with students with psychotic conditions, whereas others did not.

Other staff and students did not always have an accurate understanding of their counselling service's role. Academic and residential staff sometimes found it hard to accept that counsellors could not share information about particular students with them. The psychological support counsellors offered was noticeably more boundaried and separate from the students' everyday life than the social support given by others. Nevertheless, staff in the universities and colleges were grateful that they had counselling services to which they could refer distressed students.

The psychological support provided to students within their colleges and universities was always described as 'counselling'. In contrast the psychological support provided by the Mental Healthcare Trust was termed 'psychotherapy' or 'clinical psychology'. Despite attempts to distinguish between these terms, the literature does not provide unambiguous definitions (Dryden 2000, Feltham 2000). These writers suggest that counselling is focused on human development and growth, whereas psychotherapy is used to treat mental health problems.

In this research the above distinction was found to be basically correct, but the boundaries were blurred. For example, students' difficulty in accessing NHS provision meant that counsellors were seeing some students with serious mental health problems. They were also seeing such students for a longer period of time than their more typical counselling clients. Some of the university counsellors had previous experience of working in mental health services and were qualified at similar levels to NHS psychotherapists and clinical psychologists. The main distinction between these two groups was that the NHS psychotherapists and clinical psychologists were only seeing clients with serious mental health problems, whereas university and college counsellors were supporting students with a wide range of emotional and mental health difficulties.

Some of the literature on psychological therapies (e.g. Mellor-Clark 2000, Roth & Fonagy 1996) has attempted to evaluate the effectiveness of different psychological approaches. In discussing which approaches were most appropriate for student counselling services, Newsome (1973) argued that psychoanalytic techniques were not suitable, preferring a person-centred (Rogerian) approach. However, psychodynamic techniques, which are derived from the psychoanalytic approach, have subsequently been widely adopted in student counselling services based on a brief therapy approach (Coren 1996).

Nearly all of the student counsellors interviewed in Oxford used psychodynamic techniques in their work (Chapter 4). However, only a few used the psychodynamic approach by itself. Some described themselves as 'eclectic' adding cognitive, behavioural and Cognitive Behavioural Therapy (CBT) techniques to a psychodynamic base. Others took an 'integrative approach' combining person-centred and psychodynamic techniques. Despite this mix of approaches, the university counselling services were believed to be overwhelmingly psychodynamic in orientation by most of the practitioners working in healthcare and by some of the students in their institutions. Healthcare staff were particularly dubious of the value of the psychodynamic approach and would have liked to have seen more CBT available as there was felt to be more research evidence supporting it. Other staff working in the academic institutions

seemed indifferent to which approach was taken by their counselling services, the fact that it was 'counselling' was enough.

Only a very limited amount of formal psychological support was offered to Oxford students by primary care health services (Chapter 5). Some respondents reported that certain GPs did not encourage students to seek psychological support for depression, preferring treatment by medication instead. The GPs interviewed saw both forms of intervention as potentially useful, although they tended to prefer CBT to psychodynamic counselling. The effectiveness of medication compared with different forms of counselling for treating common mental health problems has been debated in the medical press. However, despite the availability of various research findings in the literature, this research indicates that at the primary care level in Oxford there was no consistency in the type of treatment offered to student patients.

At the secondary care level psychological support was provided by clinical psychologists within the multidisciplinary Community Mental Health Teams (Chapter 5). The dominant approach used was CBT. Psychologists and psychotherapists working within tertiary mental health services also used CBT, whilst Cognitive Analytic Therapy (CAT) and family/systemic therapy were also employed. A few respondents were critical of CBT, seeing it as addressing symptoms rather than underlying problems. In contrast, some of the practitioners using CBT felt that it could address deep-seated problems. They considered that exploring concepts such as automatic thoughts, core beliefs and internal rules with the client enabled them to go beyond the treatment of symptoms in much the same fashion as that claimed for psychodynamic therapy.

Whilst CBT was originally considered to be most effective for the treatment of neurotic conditions (Hawton et al. 1989), many of the practitioners interviewed felt that it could also be used for those with psychosis (Chapter 5). Johnstone (2000) has argued for a psychological interpretation of mental health problems including schizophrenia. Turkington and McKenna (2003) have debated the value of CBT in treating psychosis, setting out arguments for and against its effectiveness in helping patients to avoid relapse. This research found that local practitioners were most likely to believe that psychotic conditions required medical interventions, whilst psychological interventions such as CBT could be used after the acute phase to support the patient's recovery.

Debates that may seem important within counselling, psychotherapy and clinical psychology have probably had little impact on lay people. Most lay respondents did not know much (if anything) about the different approaches adopted. Some students assumed that counselling was a branch of psychiatry and the approach they were most

likely to have heard of was the Freudian one. In medical circles the CBT approach was the one most likely to be taken seriously. However, counsellors who used psychodynamic approaches and others, either in combination or singly, knew that what they were doing was making a difference even if this was not backed up with ‘scientific’ evidence. All of this points to the need for increasing the dialogue and understanding between those providing psychological support and others in the social and medical arenas.

6.4 Medicalised approaches to mental health revisited

Those interviewed who were working in a medical context did not appear to subscribe to a purely biological model of mental health. Despite their specialist roles, all were aware of the social and psychological factors which impacted on their patients’ mental health. Some regarded underlying biological factors as contributing to a person’s vulnerability to mental health problems, whilst social and psychological factors were stressors which could act as a trigger. Their views were consistent with the diathesis-stress model or bio-social approach to mental health developed by Goldberg and Huxley (1992).

These health practitioners could see the value of psychological and social interventions. They and other respondents referred to the existence of other practitioners who were more purely medical in their approach to mental health, but they themselves were happy to refer their student patients for other forms of support. In their turn, the providers of psychological and social support interviewed all saw a need for certain students at particular times to access medical services. Medical procedures were seen as particularly necessary for those with psychotic conditions and severe depression, whilst not generally providing the whole solution to the student’s problems.

6.4.1 Medical views on the causes of mental health problems

In Tyrer and Steinberg’s (1999) framework, medical interventions are often associated with a disease model, necessary when an individual has become mentally disordered beyond the social and psychological levels of disturbance. The task of the medical practitioner is to identify clusters of symptoms and from these make a formulation or diagnosis based on existing psychiatric knowledge. Having identified the patient as experiencing depression, anxiety, schizophrenia etc., the necessary treatment, often (but not necessarily) pharmacological, can then be prescribed.

In contrast to writers who have expressed doubts about the necessity of medical interventions for mental health conditions (e.g. Read et al. 2004), most respondents believed that students had medical needs when experiencing severe psychotic conditions. In some cases they were also seen to need medication to lift them out of neurotic conditions such as depression in order to engage with social or psychological support which might further aid their recovery. Some students were said to view antidepressants as a 'quick-fix' for their problems and as such preferable to counselling. Certain GPs were also said to prefer the use of medication over psychological interventions. There was more questioning of the need for a medical approach at the level of anxiety and depression than there was for the more severe mental health problems.

The medical practitioners who worked with students as patients recognised the impact of many factors including those largely specific to that population: the pressures of academic work and assessments, the effects of living in halls of residence and colleges, the competitive atmosphere, the effects of debt, the culture of alcohol and drug use and the difficulty of providing access to treatment and continuity of care within the context of term times and vacations.

It was noticeable that all of those interviewed had much less to say about the medical needs of students, compared with their psychological and social needs. This was not because medical aspects were not seen as important, rather that they were seen as established procedures that would be invoked if the student's condition was severe enough. Medical practitioners themselves spoke of following standard assessment and treatment protocols without needing to explain the underpinning philosophy. This contrasted with counsellors and psychotherapists, who provided detailed explanation and justification for their approach. Non-medical respondents sometimes expressed dissatisfaction with medical practitioners but did not offer critiques of medical models of mental health. It is possibly a measure of the higher status given to medicine (Pilgrim & Rogers 1999) that medical interventions were not questioned to the same degree as psychological interventions.

6.4.2 Medical support for students

Wessley (1996) expressed concern that mental health services were becoming increasingly focused on the treatment of psychoses at the expense of other conditions, a situation that was largely confirmed by this research. Although there were some examples of students with severe depression, anxiety, eating disorders and other serious mental conditions being treated by secondary and tertiary care services in Oxford, it was

widely felt that a significant number of students with serious, but not psychotic, mental health problems were less able to access the specialist support they needed (Chapters 4 & 5).

Very little has been written about the role of healthcare professionals who support students, and what there is tends to be dated (e.g. Lucas 1978, Ryle 1969). There have been some comments on working with medical practitioners from a counselling perspective (e.g. Bell 1996), but there has been no published research which examines the work of those who provide medical support to students. Jacobson (2002) writes on primary care provision for students from a GP's perspective, but focuses mainly on the issues raised by treating young adults in general and is less specific about those pertaining to a student population.

The GPs interviewed provided a wide range of support (Chapter 5) which included social and psychological interventions. This research found that students' choices, especially for treatment of common mental health problems, could be affected by GP's attitudes. There were students with less severe but still serious problems, who approached GPs and were not offered psychological interventions, or were told that they could 'make do' with counselling from their university's service until proper NHS psychotherapy was available. The lack of mid-range psychological services contributed to this situation. Some GPs felt that their patients needed CBT, but with waiting lists of nine months to a year they had to look at other options. Some GPs viewed university counselling services as being psychodynamically-oriented and not appropriate to their patients' needs, so offered them medication instead. Counsellors were willing to work in partnership with GPs and regretted that there were some who did not have any contact with the counselling services. These inter-professional differences affected the choices available to students.

Psychiatry, although still a distinct profession within mental health services, is increasingly part of a multi-disciplinary framework (Tyrer & Steinberg 1999). The change from asylums to community care has led to the creation of Community Mental Health Teams which require team members to work across professional boundaries. Despite the closure of the old hierarchical institutions, Busfield (1996) believes that psychiatrists will continue to play the dominant role in mental health services. Owing to its influence on mental health services, the debate on the nature and contribution of psychiatry continues (BMA 2004). The psychiatrists interviewed played a key role in assessing and diagnosing severe mental health problems, whilst relying on other team members such as psychologists, community psychiatric nurses and occupational therapists to provide the range of treatment and support required by their patients

(Chapter 5). These other team members also undertook mental health assessments and formulation of treatment plans.

At the tertiary level, specialist mental health services had a strongly psychotherapeutic element, with therapists taking referrals from psychiatrists. However, resource limitations affected what could be offered. Medical interventions tend to be cheaper than psychological ones and some patients were not able to obtain support beyond the medical level (Chapter 5). There was evidence of some tensions between proponents of medical and psychological approaches within the service. Some of the NHS managers and psychotherapists wanted to reduce the emphasis on medicalisation within particular services. There were comments that psychotherapy was viewed with suspicion in certain quarters. Such observations suggest a certain amount of inter-professional rivalry and the presence of boundary disputes which have also been noted in other mental health contexts (Pilgrim & Rogers 1999).

This research did not find any cases of respondents' adhering to a purely medical or biological model of mental health. The majority of those interviewed saw medical interventions as being necessary when an individual's levels of distress or disturbance were very high. Tyrer and Steinberg's (1999) framework was largely confirmed in that medical interventions were commonly seen as being at the top of a hierarchical structure, with social interventions at the base, and psychological interventions in-between. Critical views of the medical role tended to be more concerned with the degree to which mental health conditions were medicalised, rather than denying it any valid role in understanding and treating mental health conditions.

6.5 Integration of support: theory versus reality

Tyrer and Steinberg's (1999) integrative model links each of the social, behavioural, cognitive, psychodynamic and disease models to particular levels of functioning.

The hierarchical model indicates that for each stage of psychiatric disorder there is an appropriate model but whose application is only correct for that level of disorder. When the disorder moves to a different level, another model (or more than one) is applicable.

(Tyrer & Steinberg 1999, 120)

If this model is correct, the implications are that for an individual to receive effective treatment and support they should be able move between the different levels of interventions at the appropriate time. Within each of the organisations studied there was a recognition of the need for social, psychological and medical interventions,

although more rarely was this refined into a distinction between the need for cognitive, behavioural and psychodynamic interventions at the psychological level. Despite this recognition there were various barriers to the transition between different levels of support. The outcomes for students with mental health problems were not measured on an individual basis, but the comments of those interviewed suggest that students did suffer as a result of the lack of a joined-up approach to support.

6.5.1 Working across different approaches

Communication across the boundaries of social, psychological and medical support is not always easy and there can be a lack of understanding or even a degree of mistrust between those who occupy different positions e.g. parents, friends, tutors, counsellors, GPs and psychiatrists (Stanley & Manthorpe 2002). However, those offering social support were often keen to know when and how to encourage the more distressed students to seek psychological or medical help. Those providing psychological support often found themselves in a difficult position in relation to providers of social support. This was particularly obvious in the case of university counselling services.

University counsellors shared a code of ethics with others in their profession, which placed the client and the confidentiality of their relationship first, but they also related to the wider educational institution which employed them. They can play a role in advising others of institutional problems which are having an adverse effect on students' well-being (Rattigan 1989). They may find themselves being marginalised as the part of an institution that deals with its problems and the unpleasant aspects of academic life (Bell 1996). Some of the counsellors interviewed had developed insights into areas of university life which students had found difficult. They had ideas of how the institutions could be helped to become more 'emotionally healthy', but felt frustrated that their voice was not heard in the wider university community.

University counsellors also found themselves at the interface between psychological and medical support for students. These counsellors reported that their relationships with GPs varied from good and collaborative to poor or non-existent. In common with student counselling services in other parts of the UK (Rana et al. 1999), local university services were giving limited support to some students whose needs would have been better met by NHS psychotherapy services, but who could not gain access to them owing to resource limitations. Counsellors were not happy about this situation; they felt they were having to make up for the inadequacies in NHS provision, could not give these students the amount of therapy needed to improve their health, and

consequently struggled further with already busy workloads and waiting lists (Chapters 4 & 5).

An integrative model suggests the need for psychological interventions to follow on from medical treatment. In the organisations studied students with serious mental health problems were seen as having psychological needs, not just for treatment of their condition, but also for help in coming to terms with what had happened to them. They also needed support in managing their condition and returning to academic life after medical treatment (Chapters 4 & 5). Psychological support in relation to their mental health condition was available to a limited extent for some students who had been treated by NHS mental health services. However, support for the transition back from being a patient to a student was less likely and, when it did occur, usually fell upon hard-pressed university counselling services, often without appropriate consultation. National trends (Rana et al. 1999) were reflected locally where support for students with serious mental health problems was sometimes expected of counselling services not set up for that purpose.

The existence of multi-disciplinary Community Mental Health Teams seemed to offer the chance to put an integrative model of support and treatment into practice, but NHS resource limitations have hampered its implementation. High thresholds for the severity of symptoms required to access mental health services meant that many disturbed students did not receive specialist treatment. After recovery from an acute phase of illness, students could not expect intensive support and case management from Community Psychiatric Nurses who had large case-loads to support. As a result, students with mental health problems were thrown back on their own resources or were only helped by being noticed by proactive individuals.

Limited resources pushed health services into dealing with crisis situations and admissions, leaving less time and attention for detailed planning of what the student patient would do following discharge. Concerns about confidentiality and professional boundaries meant that, although certain professional staff might be pleased to receive information about particular students from other supporters at times of crisis or difficulty, they felt constrained about passing information back when the student returned to academic life. This applied to the relationship between residential staff and university counsellors, between university counsellors and GPs, and between mental healthcare staff and academic staff. Many respondents mentioned the lack of knowledge and understanding of the policies, procedures and support available between academic and healthcare institutions, one telling example being the confusion over the role that university counselling services could play in supporting students following

psychiatric treatment. The more intangible nature of the social support available to students returning from treatment, compared with professional models of treatment and support, made it difficult for healthcare professionals to know how to help their patients access such support.

Where an integrated approach had been achieved, through the efforts of particular individuals, there were often positive outcomes for the student. Examples of this at primary, secondary and tertiary levels of care showed the value of collaboration around issues such as: finding appropriate residential accommodation, supporting gradual re-entry to study, and managing risk. The lack of an integrated approach between sources of social, psychological and medical support was found to result in less positive consequences for students with emotional and mental health problems in Oxford.

The negative impact of a fragmented approach was different for students with the less damaging common mental health problems compared to those with severe mental illnesses. Students in Oxford with problems such as anxiety and depression were recommended to try medication, counselling or a combination of the two, depending on the views of the primary care practitioner or other professionals who had contact with them. Some students were reported to have been on anti-depressants for several months with no significant improvement in their condition. University counsellors felt that a combined approach of counselling plus medication could have led to better outcomes, but that the attitudes of certain GPs worked against this.

Students with severe mental illnesses such as schizophrenia and bi-polar disorder could often access mental health services rapidly, but some respondents felt that academic institutions could have used support in identifying the need for treatment at an earlier stage. After treatment a number of these students were felt to need help to identify and access sources of formal and informal support at the social level.

As in other university cities (Lago 2002) the presence of large numbers of students within the local population did not seem to have had an impact on the planning and delivery of mental health services within the locality. The NHS managers interviewed were aware that there were particular issues raised by the student population, but acknowledged that there was still work to be done at a strategic level if the needs of that population were to be considered separately from those of the wider population (Chapter 5).

6.5.2 Integrating support for students returning to study

The absence of systematic support for integration in universities and colleges particularly affected students with poor social skills and low self-confidence. Some students encountered difficulties in obtaining suitable accommodation after a period away from their educational institution. Although some one-off solutions were achieved through contact with student services and other staff, there was no consistent and joined-up approach between local health services and the colleges and universities, a situation not confined to Oxford (Lago 2002).

This research has indicated that different sources of support have complemented each other, with some students accessing different sources of support either sequentially or concurrently. This came about either through the initiative of the students themselves, or through the efforts of individual staff in health services or educational institutions. In some cases student-initiated use of multiple sources of help was seen as counter-productive and potentially confusing for the student. In other cases there were examples of students who were supported in their transition back to academic life through collaboration between individual health practitioners and staff in colleges/universities. These showed the value of connecting social, psychological and medical support when the student had major mental health problems (Chapters 4 & 5).

Although Tyrer and Steinberg's integrative model has played a large part in this discussion of the research findings, it is not the only model with relevance to the re-integration of students with mental health problems. The psychiatric rehabilitation model developed by Anthony et al. (1988) and the associated recovery model (Anthony 2000) propose that the best chance of recovery from severe mental illness is brought about by the combination of three different interventions. Firstly the individual's underlying pathology must be addressed by medical and/or psychological interventions. In Oxford those students whose condition was assessed as severe enough received these interventions from secondary and tertiary mental health services. Secondly the person's skills must be developed, and supports put in place, to help them cope with the impact of their condition upon their life. It was not clear where this skills development and support would come from at the local level. In some cases counsellors, disability advisers or tutors offered support to students, but this did not happen as a matter of course and was not routinely planned for upon discharge from health services. Lastly the model recommends interventions which create an enabling environment for the individual and reduce the dangers of stigma and discrimination. Although disability advisers played a role in applying this intervention within the local universities, this was not something that was specifically addressed in relation to mental health.

Anthony et al.'s rehabilitation model (1988) could be particularly relevant to supporting students' return to study as it was developed to help patients return as closely as possible to their former levels of functioning within specific environments. In practice, treatment of the students' mental health problem or 'pathology' was not followed up by an assessment of the need for skills development, personal support and changes in the social environment. Whilst the local mental health services did not have the resources to provide the interventions suggested by the model, these could be developed in collaboration within the colleges and universities. Health practitioners could identify and record students' ongoing support needs using the Care Programme Approach planning mechanism. Using this information, higher education institutions could consider providing targeted support funded by the Disabled Students Allowance. Specialist support has been funded through the DSA at the University of Southampton in the form of a personal mentoring scheme. This university has also developed an institution-wide mental health policy to clarify the support, accommodations and procedures that can be put into place¹.

6.5.3 Integrating support for students during their studies

Tyrer and Steinberg's integrative model allows for different patterns of support depending on the individual's situation. In order for students to have their differing support needs met, they needed to be able to access different levels or types of support either sequentially or concurrently. For example a student with depression might be prescribed anti-depressants by their GP, receive informal support from their friends and approach their personal tutor for advice on managing their academic work, whilst also seeing a university counsellor for psychological support. Depending on the student's situation, they might access all these sources of support independently, or there might be contact between some of the supporters alerting each other to the student's needs.

In contrast, a student developing a more severe mental health problem, such as the first onset of schizophrenia, might find that social support from fellow students and staff in their university/college rapidly diminished as their symptoms became more florid. The same student might be persuaded to visit a university counsellor who in turn would decide that counselling support was not appropriate at this stage and would refer them to a GP or to the service's psychiatric consultant. In this latter case the support is sequential rather than concurrent, moving from social to psychological to medical, as supporters at each level decide whether or not they can help the student. More

¹ http://www.hr.soton.ac.uk/equalops/asp/mental_health_policy.asp

typically, for psychotic conditions, the transition is likely to be straight from the social to the medical level. This research found evidence of both pathways.

Students who had returned to study after treatment and those who had managed to continue studying despite their mental health problems had to cope with the stresses of academic life. Students with all levels of emotional and mental health problems were at risk of dropping out of their courses if they did not receive appropriate support. Once they got behind with their academic work they found it very difficult to catch up.

Students experiencing stress, anxiety and emotional problems relied to a large extent on social support. A smaller proportion accessed psychological support from the counselling services, but counsellors were stretched by the several hundred students in each university that used their services annually. The counsellors' code of confidentiality made it difficult for them to work collaboratively with social supporters such as tutors and residential staff, although they could advise them on general approaches to take with distressed students. Staff felt reassured that they could refer students on to the counselling services when they were not able to meet the individual's needs, but the professional boundaries maintained by the counsellors sometimes made them feel frustrated. Davies (2000) has commented on the role tensions experienced by university counsellors offering individual therapy within public institutions. The individual focus and boundaries of their role restricted counsellors' ability to be part of an integrated approach, although the support they gave could complement that provided by social supporters.

The psychiatric consultants hired by university counselling services could be seen as helping to integrate medical and psychological approaches, but in practice their role was more focused on policing the divide between counselling and psychiatry. In particular they were concerned that students with serious mental health problems who attended counselling should be referred into psychiatric services.

Students with severe mental health problems were less likely to use the support of their peers, particularly as there was considerable stigma attached to such problems (Chapter 3). University counsellors did not feel that it was appropriate to offer long-term support to these students. The complexity of working with students with severe mental health problems has been acknowledged in many university and further education settings (Stanley & Manthorpe 2002). This complexity highlights the need for a systematic and integrated approach to supporting such students during their studies. In contrast, solutions in Oxford tended to be the result of individual efforts often negotiated at short notice.

Apart from the difficulties of integrating social, psychological and medical support, staff within universities and colleges faced difficulties balancing disciplinary and welfare issues (Chapter 4). Some students were asked to take time out from their studies because of the effect their behaviour was having on other students and staff. Balancing the rights of a student with mental health problems against the duty of care to other students presents challenges to individual staff and their institutions (CVCP 2000). This was an area where academic staff responsible for such decisions felt the need for training, clear policies and expert advice. Medical staff were sometimes asked to assess whether a student or potential student was fit to be at college/university. However, this was not a purely medical matter as the student's progress could depend on the quality of support available, their ability to deal with the stresses of study and on the nature of the particular social environment they would encounter.

Academic staff played a key role in supporting students during their studies, but they varied in their ability to provide appropriate support and to adapt their teaching practices according to the needs of their students. A number of individual staff members had developed good practices (Chapter 4) which could be shared and discussed with others. University counsellors and healthcare staff also had ideas of how the teaching and learning situation could be improved. Given that tutors and other academic staff were seen both as a source of stress and of support by students and other respondents, they could play a major part in developing a more enabling environment for vulnerable students.

6.5.4 Creating partnerships for integrated support

Research respondents identified a number of ways in which the planning and delivery of support and treatment services might be improved for the student population. There was a widespread desire that more resources be found for NHS provision, especially for rapid access to Cognitive Behavioural Therapy. A few favoured the employment of specialist student health practitioners employed either within the mental healthcare trust, in the local universities and colleges or as joint appointments. There was common agreement that the different providers of support and treatment should find ways of working more closely together.

The case for partnerships between mental health services and education providers has been made in recent years (e.g. CVCP 2000, RCP 2003), and local respondents were keen to promote a collaborative approach, the creation of the Oxford Student Mental Health Network in 2000 being one expression of this. Despite this impetus, the research has identified difficulties which may have hindered collaboration

between different sources of support. In part these were due to the differences in the nature of social, psychological and medical support and inter-professional rivalries, but resource issues were also a limiting factor.

The division between primary care and secondary services was felt to have increased in the re-organisation of the local health economy. Local GP surgeries and health centres serving large student populations were less able to access or commission specialist mental health and psychological services once they lost their fund-holding status and came under the umbrella of a Primary Care Trust (formerly Primary Care Group) in 1999. The waiting times for secondary and tertiary mental health services put them out of reach of many students who had serious mental health problems but did not require emergency admission. GPs did their best to support such students but felt that they were not doing much more than running a holding operation. The government's intention to increase resources for primary care mental health services may eventually lead to improvements, but during the research period the situation was felt to have deteriorated.

The development of a partnership approach has to take into account professional boundaries and corresponding concerns about confidentiality, effectiveness of different approaches and responsibility for vulnerable individuals. Boundary issues were particularly noticeable in medical staff's comments on university counselling services, to a lesser extent in counsellors' attitudes towards GPs and psychotherapists' and clinical psychologists' views of psychiatrists. The views of some GPs concerning peer supporters and the comments of health staff and counsellors on tutors and other staff in colleges and universities also raised questions about legitimate areas of involvement with students and their problems.

The sharing of information was a contentious issue. Quite rightly, professionals such as counsellors and healthcare staff took their obligations to protect their clients' privacy very seriously. However, academic, student services and residential staff felt hampered by their lack of knowledge of the circumstances surrounding certain students whom they were trying to support. To some this seemed to reflect an inferior status for, and lack of recognition of, social support and the role it could play. Lago (2002) commented that good-will was an important ingredient in fostering collaboration between universities and healthcare providers. This research found that healthcare practitioners appreciated the efforts of staff in colleges and universities who went out of their way to support their patients. The other side of the coin was that a number of respondents in the academic sector felt ill-used by healthcare staff when students with

difficult or challenging behaviour returned after treatment, without consultation or without the provision of any supporting information (Chapter 4).

Respondents from education and healthcare institutions called for greater understanding of each other's sectors. Although GPs often had a reasonable knowledge of the universities and colleges and their support structures, this was less true for staff in secondary and tertiary care services. Within the universities themselves the counselling service's role was sometimes misunderstood by both staff and students, who tended to see it as a sort of internal psychiatric service (Chapter 3). Lay views of counselling and psychotherapy (Furnham et al. 2001) have been found to influence people's willingness to access such services, and counsellors are considered to have a role to play in informing other members of their institution about what they can offer (Bell 1996). University counsellors could also give teaching staff useful feedback on those areas which students find most stressful, as well as helping staff to develop strategies which would improve their own practice.

In this research an improved dialogue between GPs and university counsellors was seen as important in increasing students' awareness of the treatment options available, particularly for common mental health problems. At secondary and tertiary levels there was an identified need to improve health practitioners' knowledge and understanding of the ways in which colleges and universities could support students with severe mental health problems. Existing mechanisms such as the Care Programme Approach did not appear to be used to aid students' transition back to academic life.

The voluntary sector provided social and psychological support for mental health problems but was not used by students in proportion to their presence in the local population. Although mental health service staff were aware of voluntary sector mental health services, staff in academic institutions were less knowledgeable of the range of support available. Providers and users of voluntary sector mental health services would have welcomed a closer relationship with local colleges and universities (Pitts 2003) and this might have been particularly appropriate for the further education sector (James 2002). Another potential source of support was that of user-led groups such as Oxford Survivors. There was no evidence that students were using this support, but if more students with mental health problems enter further and higher education in the future, user-led initiatives could become viable.

6.6 Implications of an integrated approach for the future of student support

An integrated approach to mental health is not the same as an eclectic one (Tyrer & Steinberg 1999). The latter implies that a range of approaches are taken, social

psychological and medical, without a clear basis for why and when a particular form of support is used. In an integrated approach the student's needs should be assessed and planned for, taking into account the wide range of interventions possible and how they can fit together to support the individual's recovery and academic progress. Tyrer and Steinberg's integrative model and Anthony et al.'s (1988) psychiatric rehabilitation model offer conceptual frameworks upon which to build an integrated approach. This research has not found evidence of existing integrated approaches across the academic and healthcare sectors, or between providers of social, psychological and medical support. However, individual examples of good practice have been encountered which could form a starting point for collaboration.

The psychological support provided was often valued but was not able to meet the existing demand and without a significant increase in resourcing would not be able to take on an enhanced role of supporting students back into their studies. The research indicates that more use could be made of social support following medical treatment, helping the student to deal with practical issues related to study and accommodation, as well as those of overcoming stigma, discrimination, embarrassment and social isolation. A social perspective would also ensure that improving students' mental health was not seen solely as a matter of providing individual support, but as also involving institutional change.

The views and experiences contributed by the respondents in this research project, combined with issues arising from the literature reviewed, suggest specific actions for enhancing the support given to students in Oxford (and quite possibly elsewhere):

- a) The high levels of stress and anxiety encountered suggest that action should be taken to promote the mental health of whole university and college populations in line with the Health Promoting University initiative (Tsouros et al. 1998). As well as helping students with the transition into academic life and coping with its demands, the very sources of stress, many of which have been mentioned in this thesis, should be further investigated and reviewed.
- b) Universities, colleges and healthcare providers could adopt a framework for integrating support informed by Tyrer and Steinberg's (1999) integrative model and based on the psychiatric rehabilitation model (Anthony et al. 1988). This identifies the need not only for treatment, but also for skills development, personal support and changes in the social environment. In the case of students with severe mental illness, this could be promoted by better planning for discharge using the Care Programme Approach.

- c) Universities could promote a better understanding of the distinct roles of disability advisers and university counsellors so that other supporters can help students make more appropriate use of these supports. Universities could also consider the employment of specialist mental health advisers linked to their educational support systems (Stanley & Manthorpe 2002).
- d) All institutions could recognise the role and benefits of social support, helping staff and students within educational institutions to offer appropriate non-stigmatising support. Social support was widespread, but because much of it was not formally recognised there was little in the way of support, training and advice for the supporters themselves, who could get out of their depth.
- e) Many respondents mentioned the need to respond rapidly to those students who become distressed or ill whilst at college or university, in order to prevent them from becoming more severely disturbed and dropping out of their studies. At present many students only receive specialist support after a crisis has occurred, and early intervention would be preferable. Respondents felt the need for a more systematic approach working across the education and healthcare sectors.
- f) Some students with a history of mental health problems need ongoing support. Although disability advisers and others support some students who enter university or college with an existing mental health problem, there is a need for more targeted support helping students to find ways of optimising their functioning and reducing their chances of having a relapse. One route would be for university disability services to provide individual mentoring support using the Disabled Students Allowance for funding.
- g) There could be clearer channels of communication between educational institutions and healthcare providers. Some good practice was already in place, due to individual efforts, and this could be built on. There was also a willingness to identify staff in mental health services who would take on a liaison role. The work of the Oxford Student Mental Health Network provided a model for improving communication. Links were made between senior managers in educational and healthcare institutions who formed the steering committee. Practitioners, education staff and students had the chance to meet and share experiences in workshops. Further work could be done along these lines to ensure that key players in all sectors are talking to each other and improving their ability to co-operate.

- h) At a strategic level the Oxford City Primary Care Trust should look at students as a significant part of the local population. Earlier work has been carried out in this area (Oxfordshire Health Promotion 2002, Gelder et al. 1995) but was lost in the subsequent re-organisation of local health service commissioning. A particular issue that affects students is the lack of timely access to mid-range services that fill the gap between university counselling services and acute mental health services.

One of the striking features that emerged in this research was the extent that those approached welcomed the chance to talk about students' mental health issues. Many people in a variety of roles were committed to making things better for students, had interesting ideas about what would help, and were investing time and energy in providing support. They represent a considerable source of energy and enthusiasm that could be harnessed in a collaborative approach to improve the mental well-being of the academic community in Oxford. It is possible to envisage a situation in which providers of social, psychological and medical support develop a clearer understanding of what each can contribute and move beyond individual solutions to a more community-focused approach.

Within the education sector there were ideas from counsellors, tutors and students about ways of developing more 'emotionally intelligent' approaches to teaching and learning. Residential staff had ideas for developing the social cohesion and mutual support within student communities. Healthcare staff were willing both to learn more about the environments within which students lived and studied, and to pass on relevant aspects of their knowledge of mental health issues to residential and academic staff. Despite a focus on some of the negative aspects of student life in this research, education was still seen as a source of personal growth and development with many positive things to offer, even to those who had experienced quite disabling mental health problems.

6.7 Reflections on the research

The case study approach adopted was useful in that it enabled exploration of support practices within their institutional contexts. Although research of this nature cannot prove the validity of a social, psychological or medical approach to mental health, it has shown that they can be seen as distinct and potentially complementary. Most research respondents did not articulate structured models of mental health as

found in the literature, but they were reasonably clear about what type of support they could offer.

6.7.1 Conceptual issues

Tyrer and Steinberg's (1999) framework, although originally created for psychiatry, provided a useful conceptual basis for exploring the range of support available within a community. In fact it is hard to see how their integrative model could be enacted solely by psychiatrists. The range of biological, behavioural, cognitive, psychodynamic and social interventions suggested requires inputs from professionals qualified in quite different approaches, as well as relying on support from lay people. This research also suggests that the model might benefit from acknowledging the integration of cognitive and behavioural approaches within Cognitive Behavioural Therapy. In addition there might be room to accommodate other approaches such as Person-Centred counselling and Solution-Focused Therapy. The social model presented by the authors acknowledges the impact of social forces but is rather short on detail when it comes to social interventions. A social support model could be developed, building on work such as Milne's (1999) as well as using the findings from this research on the complexities of providing support at a social level. The psychiatric rehabilitation model (Anthony et al. 1988) and the recovery model (Anthony 2000, Deegan 1988) also offer a structure for incorporating social factors such as acquiring skills, developing community supports and making changes to specific environments.

As previously mentioned, some medical practitioners doubted the value of psychodynamic therapy whilst not being against psychological interventions per se. In contrast CBT seemed to be highly valued by medical staff who saw it as having a more reliable evidence base. This presents a problem when trying to implement a conceptual integrated model, acknowledged by Tyrer and Steinberg, that practitioners can take up fixed positions for or against certain approaches. In Oxford the psychodynamic approach was widely used within university counselling services and, rather than being embraced as a useful and complementary intervention by healthcare staff, seemed to be regarded by them as an inferior form of therapy.

6.7.2 Practical research issues

Following an initial survey, it was clear that quantitative data on the level of health service usage by students was not readily available. Although some departments

were able to provide information for their particular service, such data were not routinely collected by service providers. Whilst it would have been interesting to measure clinical outcomes and their effect on student retention and progression in relation to the various services provided, this would have been a complex and time-consuming process to set up, assuming that collaboration could be obtained, and was beyond the scope of this research project.

The value of this research lies not in attempting to replicate studies which have measured the levels of distress and help-seeking behaviour of student populations but in the exploration of the views and experiences of those involved in providing support to a student population. This study is unusual in exploring the experiences of supporters within a city, rather than within one university or college. Although this meant that the coverage for each institution could not be as deep as if one single case study had been selected, it enables a comparison of perspectives between healthcare and education providers which has not been attempted before.

Although some interviews were conducted with staff in the College of Further Education, this research did not cover that sector in such depth as the two universities or the health trusts. With hindsight perhaps more time should have been devoted to developing a greater range of research contacts in FE. However, working across five different organisations was time-consuming and further education has some significantly different issues to higher education which deserve more detailed research and analysis in their own right. Similarly, if more time had been available it could have been useful to gain access to a greater number of students with personal experiences of mental health problems and to have found ways of involving more GPs. No community psychiatric nurses were interviewed and although their involvement with students was limited, they could have provided a useful perspective on issues of recovery and re-integration.

This research relied heavily on interviews for the main source of data. As discussed in Chapter 2 there is a danger that the interviewee may feel that they should come up with responses which will please the interviewer, rather than express their true thoughts or opinions. However, a diversity of views were encountered which were consistent with other evidence gathered from notes of meetings and documentary sources. Whilst the possibility that the interaction between the interviewer and interviewee can influence the data collected, the depth and the quality of the information collected goes some way to making this a risk worth taking. The researcher must be careful and sensitive in their approach, particularly when trying to keep the interviewee

on track without feeding them leading questions. The decision not to tape record interviews was based on a belief that to do so might have constrained what interviewees were prepared to say and would have been time-consuming (Chapter 2, section 2.7. With hindsight it would have been desirable to have tested these assumptions by taping a few pilot interviews and comparing the transcripts of these with notes typed during interviews. The method used (touch typing during the interview) may have had its own disadvantages in distracting the interviewee and in the demands it made upon the interviewer in order to keep pace with the flow of information generated during the interview process.

Observation was felt to be too intrusive and impractical (see Chapter 2 section 2.3) and a poor response rate to an impersonal survey all too likely. Nevertheless, observational studies could provide an interesting comparison between what people say they do and what they are actually seen to be doing. Similarly, if a good response rate could be obtained, surveys offer the opportunity to explore the views of a much greater number of respondents within a set period of time than could be achieved by interviews.

The research findings reported here can only present the perceptions of those interviewed. Although attempts were made to obtain a cross-section of views, the numbers interviewed, particularly students, academic staff, GPs and nurses were low in relation to their presence in Oxford, and therefore it may be possible that the views obtained are not necessarily typical. Respondents alluded to the existence of certain healthcare practitioners who were particularly medical in their outlook, but none that were interviewed fell into that category. Despite the positions adopted in defence of one model against another in the literature (e.g. Read 2004), none of those interviewed expressed such strong views in favour of or against any one position. Any differences in approach encountered were focused on what the respondent felt was appropriate to their role. There was some criticism of certain services being too medical in orientation, but this tended to be a matter of degree rather than an outright dismissal of a particular approach. There may have been some value in trying to seek out individuals who held more extreme views, but the main intention was to draw upon a sample of those closely involved in student support, and this did not yield such people.

6.7.3 Issues of generalisation

As discussed in Chapter 2, case studies are not usually undertaken on the basis of finding a statistically typical sample of a larger population. So any generalisations

made are the basis of themes and concepts derived from theory and from comparisons with other research findings.

Single or few cases are poor representations of a population of cases and questionable grounds for advancing grand generalisation ...

Case studies are of value for refining theory and suggesting complexities for further investigation, as well as helping to establish the limits of generalizability.

Stake 2002, 448

A number of writers (e.g. Donmoyer 2000) warn of the limitations of generalisations made on the basis of individual or collective case studies. Instead they advocate that sufficient description of each case and its context is given, so that the reader can make their own decisions about how applicable the findings are to other situations. This approach does not rule out applying theoretical concepts to the case study, but does recommend caution in making claims about discovering universal laws.

This research has attempted to follow this approach, providing descriptions of the various forms of support encountered whilst using concepts developed in the fields of sociology, social policy, psychology and psychiatry to organise the reporting of the findings. Readers with experience of providing support for students in other geographical locations should be able to make comparisons with their own situations, and can consider the conceptual framework of social, psychological and medical approaches to mental health. Comparisons with other university towns and cities are the most obvious ones, but this research may also have implications for other settings where there are dominant institutions e.g. large employers, prisons, the military, where there is some sense of responsibility to those within the institution. The exploration of social, psychological and medical support also has wider relevance to the general population and their mental health needs.

6.7.4 Possibilities for future research

The case studies raised questions which were beyond the scope and resources of this research project, but which could usefully be followed up in the future:

- a) Why are such high levels of anxiety found in surveys of student populations?

This research has suggested many possible factors which may make students vulnerable and may act as stressors, only some of which are age-related, but which have the most significant impact? A deeper understanding of the stress and vulnerability factors affecting student populations could highlight health-promoting actions and preventative measures which could be prioritised for this

group. Research could also explore whether such measures could benefit other students with a history of severe mental health problems.

- b) This research touched upon students' attitudes towards seeking help but did not explore them in depth as the focus was on the provision of support. Further research could investigate how attitudes towards seeking help for mental health problems are shaped. It would also be useful to explore the effect of gender differences, age, social class and cultural/ethnic background on help-seeking behaviour. Students seemed particularly wary of accessing professional sources of help. A comparative study could consider to what extent students differ from other sections of the population in this respect.
- c) What referral or treatment options are typically offered to students with emotional or common mental health problems by GPs, counsellors and others at the primary care level? Locally it was suggested that GPs might offer either medication, counselling or a combination of the two depending on their personal preferences. It would be valuable to compare the treatment recommendations made by different practitioners through a quantitative approach in order to measure the extent to which patients are offered a choice.
- d) The two universities studied had very different cultures and institutional frameworks. A further piece of research could explore the impact of organisational dynamics on the helping process. This research indicated that the close collegial structure of an old university promoted a level of concern for student welfare throughout a wide range of social supporters. In contrast the more centralised and impersonal modern university relied on a professional student services department to organise and provide support. This is just one example of how organisations differ. Further research could find many other variables to explore including differences in managerial approach, funding structures, historical development, geographical location and influences of key individuals.
- e) How many students use primary care, secondary and tertiary care services and what are the outcomes for them following treatment? If, as suggested, students are particularly vulnerable to mental health problems but also resistant to seeking help, how is this reflected in their use of services? Healthcare trusts could log the numbers of students treated for mental health problems and compare their level of service use to their presence in the local population. Follow-up studies could attempt to record whether students were able to

continue with their studies following treatment. This information would be useful in the planning of primary care and mental health services in university cities and towns.

- f) The interprofessional differences between certain providers of support and treatment showed elements of rivalry and competition. Further research could explore the attitudes that General Practitioners, psychiatrists, psychologists, psychotherapists and counsellors held towards each other's different practices and their particular claims on certain types of client. If better partnerships are to be developed, an understanding of what divides and what unites practitioners would be a useful starting point. This research found that perceptions of psychological and medical orientations were important factors. Others might include issues of training, professional standing, power and status.
- g) It was striking that the NHS staff interviewed had such a strong preference for Cognitive Behavioural Therapy above other approaches to counselling and psychotherapy and were particularly suspicious of a psychodynamic approach. This seemed to be linked to the beliefs that there was a stronger evidence base for CBT and that psychodynamic therapy either did not work or could not achieve anything worthwhile when used as a brief intervention. Further research could investigate the basis upon which such beliefs are founded and explore other reasons for the current health service preference for CBT.¹ In addition, comparative research into the use and effectiveness of brief psychodynamic therapy, CBT and other approaches could highlight the extent to which real differences exist between them in the counselling relationship.
- h) This research indicated that the requirements for confidentiality in practitioner-client relationships sometimes hindered the helping process and that clients were not routinely consulted on the sharing of information. This occurs at a time when a more joined-up approach to care is being advocated. Further research into the factors influencing decisions regarding whether or not to share information about a client with another party could help in the development of protocols around confidentiality issues. Client consent would be a very important factor to take into account.
- i) What constitutes good practice in providing a supportive teaching and learning environment for students with emotional and mental health problems? Students with physical and sensory impairments are benefiting from practical adaptations and technical aids which help to overcome the disabling barriers they encounter.

There is a lack of research-based evidence to show how students with mental health problems could similarly be enabled to get the best out of lectures, seminars, workshops, self-directed study and other forms of teaching and learning.

6.8 Summary

The distinction between social, psychological and medical approaches to mental health provided a useful framework for understanding the support offered to students. Social support was found to be important but less structured than other interventions. Those providing social support were not likely to receive information about individual students and their needs from healthcare or counselling professionals and therefore felt disadvantaged. Psychological support was valued when social support was no longer sufficient, but access to NHS psychological provision was quite limited. The role of counsellors in universities was not always fully understood and there were differences of opinion as to which psychological approaches they should employ. Medical support was deemed necessary for students with the most severe mental health conditions. Some services were seen to be over medicalised, but the value of medical interventions for severe problems was not questioned. The route back to social and psychological support from medical treatment was not well-developed, compared with the referral routes into psychiatric services.

The adoption of an integrated model could lead to each of the different forms of support being used more effectively, supporting students back into academic life and helping to retain them there through periods of difficulty. Students were especially affected by academic stresses and their distinctive lifestyles and it would be useful to understand this when planning their support needs. The way that universities and colleges are structured was found to have a potentially disabling impact on vulnerable students, a factor which recent disability discrimination legislation would require institutions to take into account.

Although this research could not cover all the providers of support in depth, it does uniquely provide a picture of the network of support available within a university city. Recommendations have been made for improving collaboration between healthcare and educational institutions and suggestions given for further areas of research.

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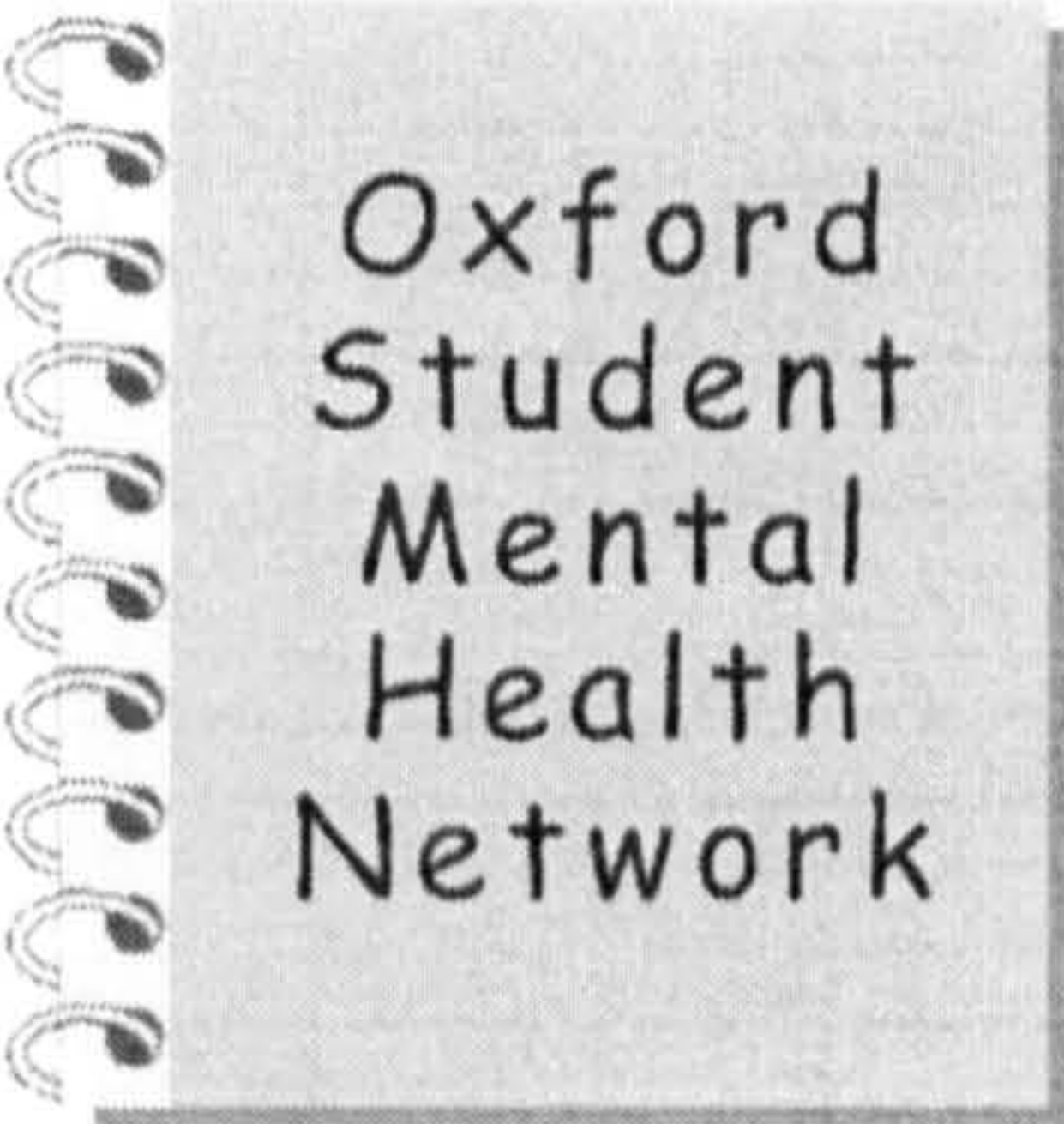
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Appendix 1

Appendix 1.1 Glossary of acronyms and abbreviations

AMOSSHE	Association of Managers of Student Services in Higher Education
AQREC	Applied and Qualitative Research Ethics Committee
ATA	Alternatives to Admission
CAB	Citizens Advice Bureau
CAT	Cognitive Analytic Therapy
CBT	Cognitive Behavioural Therapy
CFE	College of Further Education
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CVCP	Committee of Vice Chancellors and Principals
DRC	Disability Rights Commission
DSA	Disabled Students Allowance
FE	Further Education
GHQ	General Health Questionnaire
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HE	Higher Education
HEFCE	Higher Education Funding Council for England
JCR	Junior Common Room
NHS	National Health Service
OCD	Obsessive Compulsive Disorder
OSMHN	Oxford Student Mental Health Network
OT	Occupational Therapist/Occupational Therapy
OUCS	Oxford University Counselling Service
OUSU	Oxford University Students Union
PCT	Primary Care Trust
PTSD	Post Traumatic Stress Disorder
QAA	Quality Assurance Agency
RAE	Research Assessment Exercise
RCP	Royal College of Psychiatrists
RMN	Registered Mental Nurse
SMI	Severe Mental Illness
UUK	Universities UK
WHO	World Health Organisation

Appendix 1.2 Examples of interview questions for semi-structured interviews

<p>Interviews with practitioners</p> <p>Secondary Care Staff</p>	
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Check that respondent has read the Information Sheet.

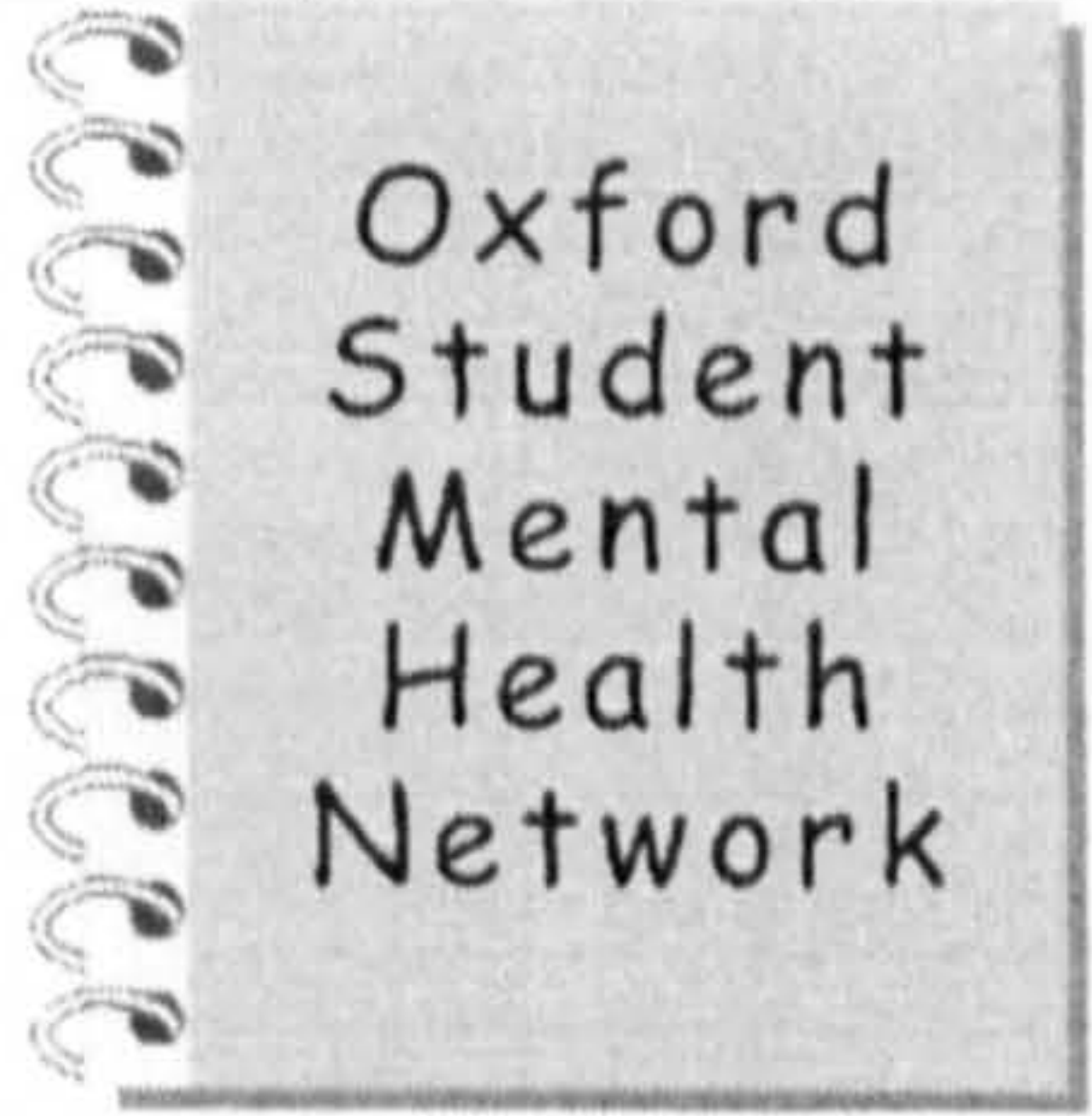
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Respondent and researcher to sign the Consent Form.

Date:

1. What sort of mental health problems are presented by any clients who are, or are likely to become students? And how do they come to your attention?
2. What criteria do you use to assess whether the client would benefit from your service? What areas would you cover in your assessment? (*What constitutes an appropriate client for psychiatric intervention?*)
3. What do you offer and how does it help these clients? (*What models of mental health does the service/practitioner operate from?*)
4. Do you feel that most student clients referred to you are appropriate for what you can offer? (*Can this be roughly quantified?*) Are there any issues to do with this for those who refer student clients to you? (*e.g. their understanding of appropriate referral criteria*).
5. What else has the client tried before reaching this stage? (*Services, strategies*)
6. What might be the reasons for these other avenues of support/treatment/self-help not meeting the clients' needs? (*What lies behind the clients' difficulty in dealing with these problems by other means?*)
7. What issues arise in relation to the student's academic institution? (*The impact of the institution on the client's well being. Issues of communication between the practitioner and staff in the academic institution*). Are there any ongoing, recent or significant cases that illustrate particular issues?
8. When additional support is needed, what issues arise in relation to access to other support/treatment services? Are there issues around support after discharge from your service? (*e.g. Waiting lists, referral criteria, communications issues, lack of ongoing support*).
9. What happens to those student clients that the service cannot help, or feels that it would be inappropriate to help?
10. How well could your service cope with an increase in the number of students entering with known mental health problems?
11. Any other issues? (*Anything not covered. Recommendations for improvements etc*)

Appendix 1.3 Examples of interview questions for semi-structured interviews

Interviews with practitioners Counsellors	
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Check that respondent has read the Information Sheet.

Code:

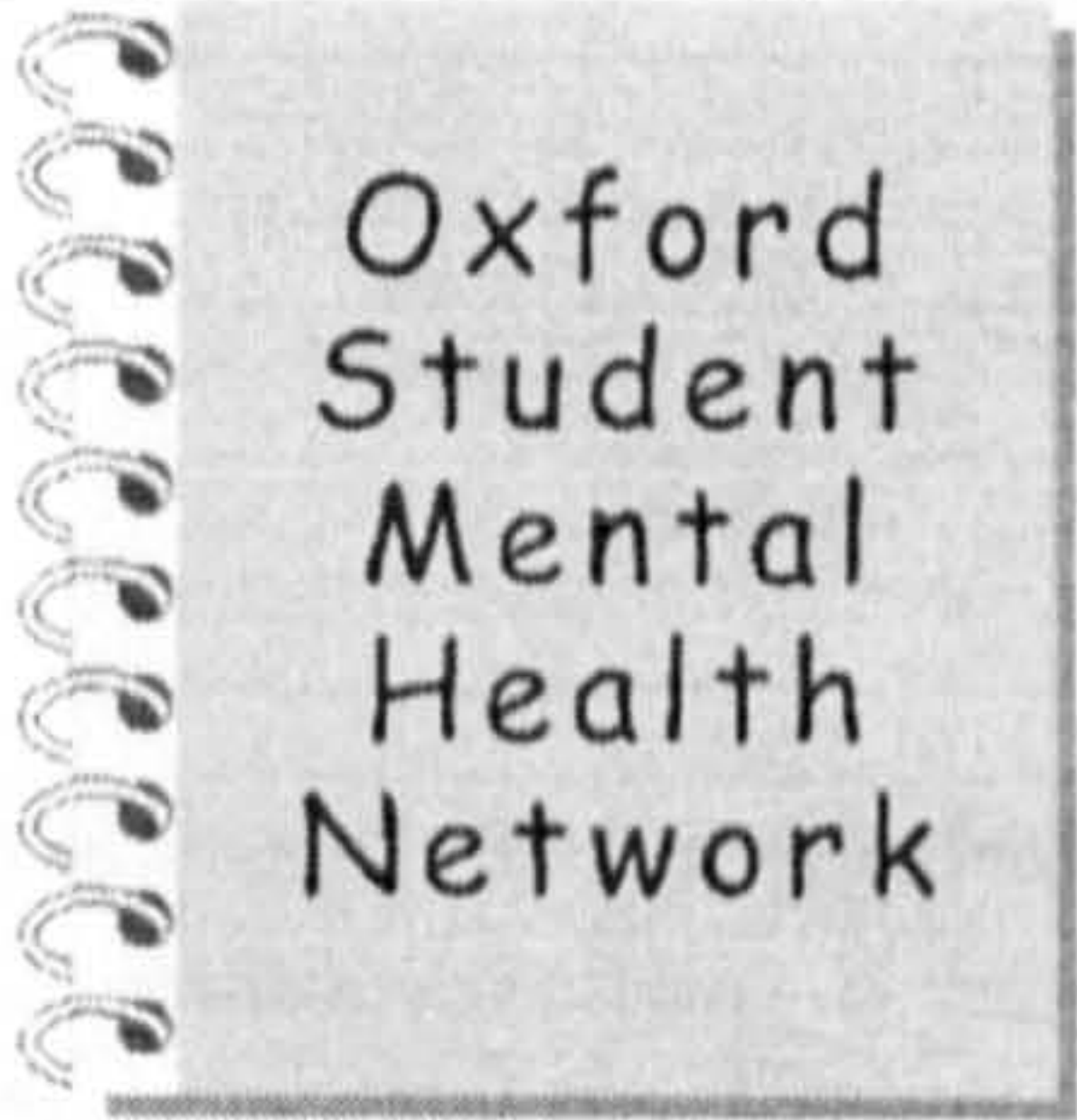
Respondent and researcher to sign the Consent Form.

Date:

1. How is the client assessed as being suitable for counselling? (*What constitutes an appropriate client for counselling? What are the referral routes?*)
2. What proportion of clients are considered to be appropriate?
3. What else has the client tried?
4. What lies behind the clients' inability to deal with these problems by other means?
5. How does the counselling process help these clients? (*What models of mental health does the service operate from?*)
6. What qualifications are required for practitioners?
7. What issues arise in relation to the academic institution? (*What are the links between internal and external factors in the client's emotional well-being/mental health?*)
8. When additional support is needed, what issues arise in relation to access to other support/treatment services? (*How does the counselling service tie in with other sources of support?*)
9. What happens to those clients that the service cannot help, feels that it would be inappropriate to help?
10. What problems are presented in relation to mental health? Are there any ongoing or recent cases that illustrate particular issues?
11. How well could the institution cope with an increase in the number of students entering with a known mental health problem?

Any other issues?

Appendix 1.4 Examples of interview questions for semi-structured interviews

<p>Interviews with residential staff</p> <p>Hall Wardens</p>	
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Check that respondent has read the Information Sheet.

Code:

Respondent and researcher to sign the Consent Form.

Date:

1. To what extent do you encounter MH problems among students? Has there been any increase?
2. What form do these problems take? (*How do they manifest themselves? Interpretations of mental health*)
3. What is the effect on the residential community?
4. How do you respond to these problems? (*What type of support do you offer?*)
5. What other services are called upon? And do they meet the need?
6. What would help in the future?
7. What support/training is needed for wardens?
8. Do you have any concerns about an increase in the number of students with MH problems?
9. Any other issues?

Appendix 1.5 Letter to potential research participants

Study Number: OSMHN 1

AQREC Number: A01.035

Dear

I am writing to ask for your collaboration in research that I am carrying out for the Oxford Student Mental Health Network (OSMHN). This research project is about making a real difference to students' mental health and emotional well-being in Oxford, focusing on the inter-relationship of the various agencies concerned. The project is supported by Oxfordshire Mental Healthcare NHS Trust, Oxford City Primary Care Trust, Oxford Brookes University, Oxford College of Further Education and the University of Oxford. Some of the research material will also contribute towards a PhD I am working towards at Oxford Brookes University, entitled "*Organisational responses to students' mental health needs: social, psychological and medical perspectives*".

I would value your contribution as someone who has direct experience in this area. If you agree to take part, you would be interviewed for approximately 60 minutes on your experiences of supporting students with mental or emotional difficulties. If there was a lot of information to cover from your experiences, you might be asked if you would be prepared to take part in a follow-up interview. This would be entirely up to you and you would not be placed under any pressure. If you work in a team there will be an opportunity to also meet as a group in order to explore some of the issues that have been raised in connection with your service. The interview would cover:

- the type of service offered
- the level of need for the service and the demands this places upon practitioners
- the appropriateness of referrals to the service
- issues that arise in dealing with this client group
- issues that arise in dealing with other institutions
- gaps in provision for this particular population

Any information collected will be regarded as confidential and I do not expect you to give any details that would identify individual clients. You will have the opportunity to review the relevant sections of any reports produced before they are made more widely available. The findings will be presented in broad categories (e.g. tutors, counsellors, GPs, nurses etc.) rather than being attributed to individuals. The results will be used to make recommendations on how services for students should be developed, and to identify what role can be most usefully played by a network of service providers and other concerned parties. The PhD aspect of the research will add greater depth to these findings by exploring how the different approaches to mental health used by diverse agencies, might meet different aspects of need presented.

I would be pleased to hear from you regarding convenient times for meeting up. I can be fairly flexible about when to meet and can be contacted at jleach@brookes.ac.uk or on Oxford 488128. In the meantime if you have any concerns about this research feel free to contact me on the above number, or the Project Director Madeleine Collin (Oxford Brookes University) on 01865 484658. If you have any concerns regarding the PhD aspect of the research please either contact me, or my Director of Studies, Dr John Hall (Consultant Clinical Psychologist, Warneford Hospital, Oxford) on 01865 226430.

Yours sincerely

Jonathan Leach

Project Manager/Researcher

OSMHN

Appendix 1.6 Information sheet for research participants

Organisational responses to students' mental health needs: social, psychological and medical perspectives

Study no: OSMHN 1

AQREC Number: A01.035

Invitation to take part in a research interview

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with colleagues or friends if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

This is a three year research project focusing on student mental and emotional health in Oxford. It is concerned with supporting the provision of services which

- promote mental well-being amongst the student population
- support students who develop mental/emotional problems during their studies
- support people with a history of mental/emotional problems who are entering Further or Higher Education.

In order to do this we are gathering information on:

- the support services available to students
- the approaches to mental health adopted by different agencies and practitioners offering support services
- students' need for these services
- the ways in which students use these services
- what happens when the support ends
- real and apparent problems concerning the services available
- what can be done to enhance students' mental and emotional well being

The results will be used to make recommendations for future provision of support. In addition, I am writing a thesis on this subject for a Ph.D. at Oxford Brookes University and would like include the experiences of practitioners in this work.

Why have I been chosen?

We wish to hear directly from staff or students who have experience supporting students through emotional and mental difficulties. You have been chosen because your job role is very relevant to this research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you would be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your employment or academic status in any way.

What would happen to me if I take part?

You would be interviewed for approximately 60 minutes on your experiences of supporting students with mental or emotional difficulties. You would not be asked to give any details which would identify individual students/clients. The researcher would book a quiet room in an agreed location in which to meet. If there was a lot of information to cover from your experiences, you might be asked if you would be prepared to take part in a follow-up interview. This would be entirely up to you and you would not be placed under any pressure. If you work in a team there would be an opportunity to also meet as a group in order to explore some of the issues that have been raised in connection with your service. The research project will continue until December 2002.

The research method being used is the case study approach. This means that each academic institution, and each service that provides support to students with mental or emotional difficulties is looked at as a whole. Interviews are conducted with students and staff, and other information is consulted such as annual reports, brochures and leaflets. A picture is built up of what type of support is offered, how well this support works, what effect the policies and procedures of the organisation have on students, and what improvements might be made. The research will also investigate how well different organisations work together when there is a need for the student to access support outside of their University or College.

What are the possible disadvantages and risks of taking part?

We would hope there would be no risks or disadvantages in taking part. The only risk we can think of, is that you might be concerned about breaching the confidentiality of your clients. As mentioned above, we would not want you to reveal any details which could lead to individual students being identified.

What are the possible benefits of taking part?

The main benefit for you would be the chance to get your views heard on how the quality of support for students can be improved in the future. We hope that students and staff as a whole would benefit from the recommendations which arise from this research.

Would my taking part in this study be kept confidential?

All information which is collected from you during the course of the research would be kept strictly confidential. Your name, address and any other details which might identify you would not be recorded on the notes made during and after the interview. A code number would be allocated to the interview notes and your name and contact details would be kept separately from these records and would be destroyed at the end of the research period. All records would be kept in a locked filing cabinet. Computer files would be password protected.

What would happen to the results of the research study?

You would not be personally identified in any publication of the results of this study. The findings will be grouped under headings such as "students", "tutors", "counsellors" etc. We would like to build up some anonymous case studies which typify some common issues presented in your work with students; these would not be published without your permission. The results of the research will be presented in the form of annual reports to the members of the Oxford Student Mental Health Network. A final report will be completed in December 2002. Some aspects of the research may be published in journals or magazines concerned with education and health issues. By September 2003 the researcher hopes to have written up the research in the form of a PhD thesis. If you would like to receive a summary of the research report please contact OSMHN on 01865 488128.

Who is organising and funding the research?

This research project is being funded by the Higher Education Funding Council for England, and is overseen by a Steering Group made up of senior members of the following institutions:

- Oxford College of Further Education
- Oxford Brookes University
- University of Oxford
- Oxfordshire Mental Healthcare NHS Trust
- Oxford City primary Care Trust

Who has reviewed the study?

This study has been reviewed by the Research Degrees Board of Oxford Brookes University, the Research Ethics Officer at Oxford Brookes University School of Healthcare and approved by the Applied and Qualitative Research Ethics Committee (Oxford Radcliffe Hospitals NHS Trust).

What if something goes wrong?

If you have any grievance arising from taking part in this research you can contact the Project Director Madeleine Collin on 01865 484658, or the Chairman of the OSMHN Steering Group Keith Cooper on 01865 484652, who will investigate your complaints. You may also the Research Ethics Officer at the School of Health Care, Oxford Brookes University on 01865 485523.

Contact for Further Information

For further information please contact Jonathan Leach on 01865 488128, e-mail: jleach@brookes.ac.uk

Thank you for reading this information sheet. You will be given a copy of this sheet and a signed consent form to keep.

Practitioner Respondent's information sheet 03.07.2001. Version 2

Appendix 1.7 Consent form for research participants

Study Number: OSMHN 1

AQREC Number: A01.035

Organisational responses to students’ mental health needs: social, psychological and medical perspectives

Name of Researcher: Jonathan Leach

Please initial box

1.

I confirm that I have read and understand the information sheet dated 03.07.01 (version 2) for the above study and have had the opportunity to ask questions.

☐
2.

I understand that my participation is voluntary and that I am free to withdraw at, any time without giving any reason, without my academic status, employment status or legal rights being affected.

☐
3.

I agree that any words I may say during the interview can be used, anonymously, in the presentation of the research.

☐
4.

I agree to take part in the above study.

☐

Name of Respondent

Date

Signature

Researcher

Date

Signature

1 copy for respondent; 1 for researcher.

Appendix 1.8 Guidelines for personal safety

Oxford Student Mental Health Network

Organisational responses to students' mental health needs: social, psychological and medical perspectives

Study no: OSMHN 1

AQREC Number: A01.035

Guidelines for minimising risk whilst carrying out interviews with students.

Whilst it is unlikely that there will be any personal risk to the researcher, the nature of the research process does require meetings with students who may have experienced emotional or mental distress. These meetings will be on a one-to-one basis and it is good practice to have considered how any problems could be handled. The following guidelines will be followed with discretion and will not be carried out in any way that is disrespectful of the respondent.

1. The interviews will be conducted in a quiet room within a building where other people are working nearby.
2. The researcher will sit near to the door in case a hasty exit has to be made.
3. The researcher will carry a personal attack alarm and a mobile phone.
4. The researcher will have a list of numbers to contact in an emergency e.g. police and site security services.
4. Details of the person being interviewed and the interview location will be left with another member of staff.
5. The researcher will use appropriate verbal and body language to attempt to defuse any challenging situations.
7. The interview will be terminated if there any signs of aggression or other inappropriate behaviour.
8. The researcher will record any incidents that give cause for concern e.g. inappropriate sexual behaviour and discuss these with his supervisor or other designated person at the soonest opportunity. (See also guidelines on minimising risk to the respondent).
9. The researcher will attend a refresher course on dealing with challenging behaviour. However, despite any techniques that may be learnt, the researcher will not be expected to take any personal risks in dealing with challenging behaviour.

Appendix 1.9 Guidelines for minimising distress for student research respondents

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Guidelines for minimising distress for student respondents

There is some risk that asking students to give feedback on a period when their mental/emotional health was challenged may provoke some re-stimulated distress. The researcher will draw upon his experience of working within a mental health setting to minimise this risk. The researcher has training in, and experience of, basic counselling skills, which will help in the setting of appropriate boundaries.

- 1. Discussion will focus attention away from how the student was feeling, towards an evaluation of the support they received at the time of their ill-health.**
- 2. If the student does require further support as a result of the interview, the researcher will ensure that they have details of suitable support agencies.**
- 3. Where an assessment is made that the student's behaviour poses a grave risk to the physical safety of members of the public, then there may be a sharing of this information with appropriate staff and relevant external agencies. Normally the student's consent should be obtained to share the information. However, it will not be necessary for the researcher to obtain a student's consent to the sharing of this information if there is a judgement that to do so would increase the levels of risk around the student.***
- 4. Where an assessment is made that a student is threatening self-harm, consideration should be given to sharing this information with appropriate staff and relevant external agencies. Normally, the student's consent should be obtained to sharing relevant information and/or the student should be encouraged to share the information with other University or College staff involved in his/her support, care and guidance, unless it is considered that seeking such consent would increase the levels of risk around the student.***
- 5. In addition to making contact with relevant staff or external agencies, if the researcher had any concerns about safety or risk issues following an interview, he will contact, depending on availability, one of the following: the OSMHN Project Director, the Chair of the OSMHN Steering Group, another member of the OSMHN Steering Group. This will be done as soon after the event as possible. A record will be made of the situation encountered and the action agreed.**

*** Based on a protocol devised by the Counselling and Advice Services Liaison Group at Oxford Brookes University 2001**

Appendix 1.10 Procedures for protecting confidentiality

Oxford Student Mental Health Network

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Study no: OSMHN 1

AQREC Number: A01.035

Procedures for protecting the confidentiality of research data and the anonymity of research respondents.

All respondents will be given an information sheet explaining what data will be collected and how it will be used. Respondents will be asked to sign a consent form stating that they have read and agreed the contents of the information sheet.

Paper-based forms and computer files containing data from research interviews are to be identified by code letters must not contain personal names.

All computer files containing interview notes are to be password protected. This includes any transmitted by electronic mail.

All paper-based versions of interview notes and consent forms are to be kept in the locked filing cabinet.

All completed survey forms are to be kept in the locked filing cabinet.

No personal information is to be shared with parties outside of the research team unless there is judged to be a strong risk that the respondent could cause physical harm to self or others. In this case the guidelines developed by Oxford Brookes University's Counselling and Advice Liaison Group will be followed. (Guidelines attached).

Any details which could identify individual respondents are to be removed from published reports of the research.

Where sections of any research report are likely to be identified with an individual person or organisation, that person or a representative of the organisation is to be given the relevant section for review prior to publication.

At the end of the research project all records containing personal information will be destroyed.

Jonathan Leach 16.03.01

Appendix 1.11 Example of a typical length interview

Interview with practitioner Code OXB 005 Date: 28.3.01

How is the client assessed as being suitable for counselling? (What constitutes an appropriate client for counselling?)

Respondent (R) would start by asking the student what bring them to counselling? The discussion follows from what is their presenting concern?

One current client with a question mark about their suitability. R is considering contacting the counselling service's psychiatric consultant about the student because she is clearly seriously depressed and this also coming out on the CORE sheet. Student is on Prozac from her GP and is finding it difficult to function. R feels that they can work together and doesn't need to refer her to another agency yet.

R's supervisor agreed that she/he could work with a student long term as it was felt she needed more than six session. Bulimia was not the presenting issue, but it was the bulimia that was getting her down. She was on anti-depressants. R has worked with her from October and will see her through to the end of her course. The student was not able to work and now she has been able to do academic work and is on her last piece of assessed work, if she had not come to counselling, that probably wouldn't have been the case. The student had had a year out.

With the depressed student, the Respondent's gut feeling is that the condition is not something that could take the student elsewhere, but R would have been looking to contact the GP or the service's psychiatrist if the student had not been under the GP already.

R had a student who presented herself as unhappy. She came to counselling after she first had a panic attack. R felt she had stuff going on. Friends might not have helped her because she was needing to look at and acknowledge feelings. One student came in wanting to know whether to finish with boyfriend or not, but it went deeper than that.

What proportion of clients are considered to be appropriate?

Respondent has seen eight clients so far and none have been inappropriate.

What else has the client tried?

It is interesting to look at what their support network is. Out the eight students seen: four self-referred, one referred by girlfriend, one by family member, one by GP and one by a friend. It tends to be a matter of coming when at the "end of their tether" in many cases, certainly true of the two student mentioned earlier (one with bulimia and the other depressed).

When functioning on courses starts to be affected they may recognise the need to come for counselling. A couple have said work is going well, others really struggle getting into a downward spiral of feeling bad and work suffering.

Respondent sees role as one of breaking the vicious circle. She/he doesn't think that students see any stigma in seeking counselling, this shown by the fact that they have friends who say "go". It is more a sense of relief that there is someone who is not judging them and will be there for them.

What lies behind the clients' inability to deal with these problems by other means?

Respondent thinks that a common denominator is parental separation, which seems to come up frequently. Of the clients seen, R has had only one (who came once only) who didn't have a separation of their parents. There have been a couple of students whose parents split-up shortly before coming to university. Then coming away to here it became too much, another separation. There are issues of learning to function on own away from home. There is confusion too, because they have not got a firm secure base; the childhood that seemed secure

was shattered shortly before coming away. In a couple of cases parents have been moving abroad.

How does the counselling process help these clients? (What models of mental health does the service operate from?)

In the approximately six sessions offered, Respondent would encourage them to focus on a particular aspect of their difficulty e.g. one girl whose parents separated during her A-levels, was trying to look after her parents (this was true of another student too). The realisation that the student is trying to look after her mother demonstrates the essence of brief counselling. It is about recognising something they are doing and they can take away and work on. One needs to realise that the short work can focus one on one important thing that can affect larger areas of the student's life.

Respondent takes a psychodynamic approach. May look at transference or not, it is not always clear in short work.

The process is looking at repeating patterns in the student's life and where they might have come from. With a depressed person R might take a more person-centred approach, being with the person and holding things for them. If they are in pieces they need holding rather than opening up.

The approach taken depends on what is appropriate at the time e.g. whether or not to feedback on what family situation is doing to the person. R was tempted to work cognitively with a girl that was putting herself down a lot.

Once off the psychodynamic training course R will work within an integrative approach, as that way seems best, especially in short term counselling work.

Those who work psychodynamically see a danger in cognitive work, in that it will cause the problem to pop up elsewhere in the person's life, due to not dealing with deeper causes. Cognitive Analytic Theory possibly pick ups on both approaches and might be worth looking at for the future. Respondent wonders about the value of a pure cognitive approach but a psychodynamic approach can take long time, and that is an issue in this context.

What qualifications are required for practitioners?

Respondent has taken a certificate in psychodynamic counselling and is now taking a diploma in psychodynamic counselling which will qualify him/her for this type of work.

There is a need for curiosity about people. You can become addicted to this sort of work on how people tick. You do need a deep interest in how people work. Genuiness, positive regard and empathy are all necessary qualities.

What issues arise in relation to the academic institution? (What are the links between internal and external factors in the client's emotional well-being/mental health?)

The university has been a very valuable placement.

The weight of work from courses seems to be a feature. It is difficult to distinguish whether it is that certain types of student find it difficult, or is it the course that is the source of the problem. Would they be going to counselling if they weren't at university? In most cases they would probably have ended in counselling whether or not they were students, 75% certainly. Perhaps over half might have felt the need for support later i.e. it was coming to university that provided the trigger now. One would hope that if students have a good experience of counselling now, they would consider it as a possibility which is acceptable again if they have future problems. So it can be seen as another part of their learning, especially for some who find it very hard to come. There was one student who had just one session, who was stuck with his work, R suggested that subsequently he should see his tutor and that worked well. R will do that again if the problem is to do with work. On the whole tutors seem to have worked well with his/her student clients, they do get support from tutors. R wonders whether it might possible to ascertain why some have got that support, and why it didn't occur to others to approach their

tutor. Is it the way that the tutor has or has not worked with them. Respondent doesn't think they see much of their tutors except for occasional academic support, but most get that academic support.

When additional support is needed, what issues arise in relation to access to other support/treatment services? (How does the counselling service tie in with other sources of support?)

Respondent has limited experience of this area. Three of the eighth students seen have been on anti-depressants: one from GP here, one for home GP and the third also prescribed here. In this last case R is not sure what else is available for her. Nothing else may be available. In the case of the bulimic student there is not much available unless they are nearly dying, then they can get into the Warneford. R doesn't know if a specialist eating disorder unit is necessary, counselling has worked well but has taken a whole year. The Eating Disorder specialist at the old university's counselling service maintains that you can't work short term with such student, so it is difficult to do this work in the context of brief therapy, but R is new to here and this is only his/her own feeling.

In the case of the student with depression, the Respondent has access to the counselling service's psychiatric consultant and feels supported there, but doesn't really know what is available if the student was deemed to need further intervention. The student has not had counselling before but is on Prozac - why has the GP not offered anything else apart from medication?

What happens to those clients that the service cannot help, feels that it would be inappropriate to help?

As discussed above most are appropriate, but sometimes additional support is needed.

What problems are presented in relation to mental health? Are there any ongoing or recent cases that illustrate particular issues?

Problems can show up as not being able cope with what they are being asked to do academically. Sleep can be a problem. Becoming depressed so that they can't start on anything, functioning breaking down.

How well could the institution cope with an increase in the number of students entering with a known mental health problem?

The Counselling team is pretty stretched at present, there are concerns over the waiting list this term, so there would be a need for increased provision. Respondent wonders whether there could be increased awareness by tutors of the problems experienced by people with mental health problems and for them to know when to refer.

The Modular scheme causes stress especially towards the end of term. Would it be possible for someone coming in with known MH problems to have tutor who specialised in, and was able to offer the support, the student needed, without stigmatising those students? Not all staff will have the sympathy or empathy needed hence the suggestion for specialists. This is an issue to be addressed on a day to day basis, but is fraught with all sorts of confidentiality issues.

Provision for these students may link with the Disabled Students' Adviser and whoever allocates tutors.

Any other issues?

No burning issues. working with CORE assessment tool and it looks interesting, although initially sceptical, R is picking up that CORE does reflect what is heard in the session.

Appendix 1.12 Workshops run as part of the Oxford Student Mental Health Network

Understanding student mental health in Higher and Further Education - Summer 2001

Eating disorders amongst students - Summer 2001

Supporting students with mental health difficulties - Autumn 2001

Developing emotional literacy - Autumn 2001

Supporting students with serious mental health problems Spring 2002

Making teaching and learning strategies more effective by taking account of emotional and psychological well-being – Spring 2002

Supporting students with mental health problems – what can staff do? Summer 2002

Emotional intelligence in teaching and learning – practical strategies – Summer 2002

Supporting students who self-harm - Autumn 2002

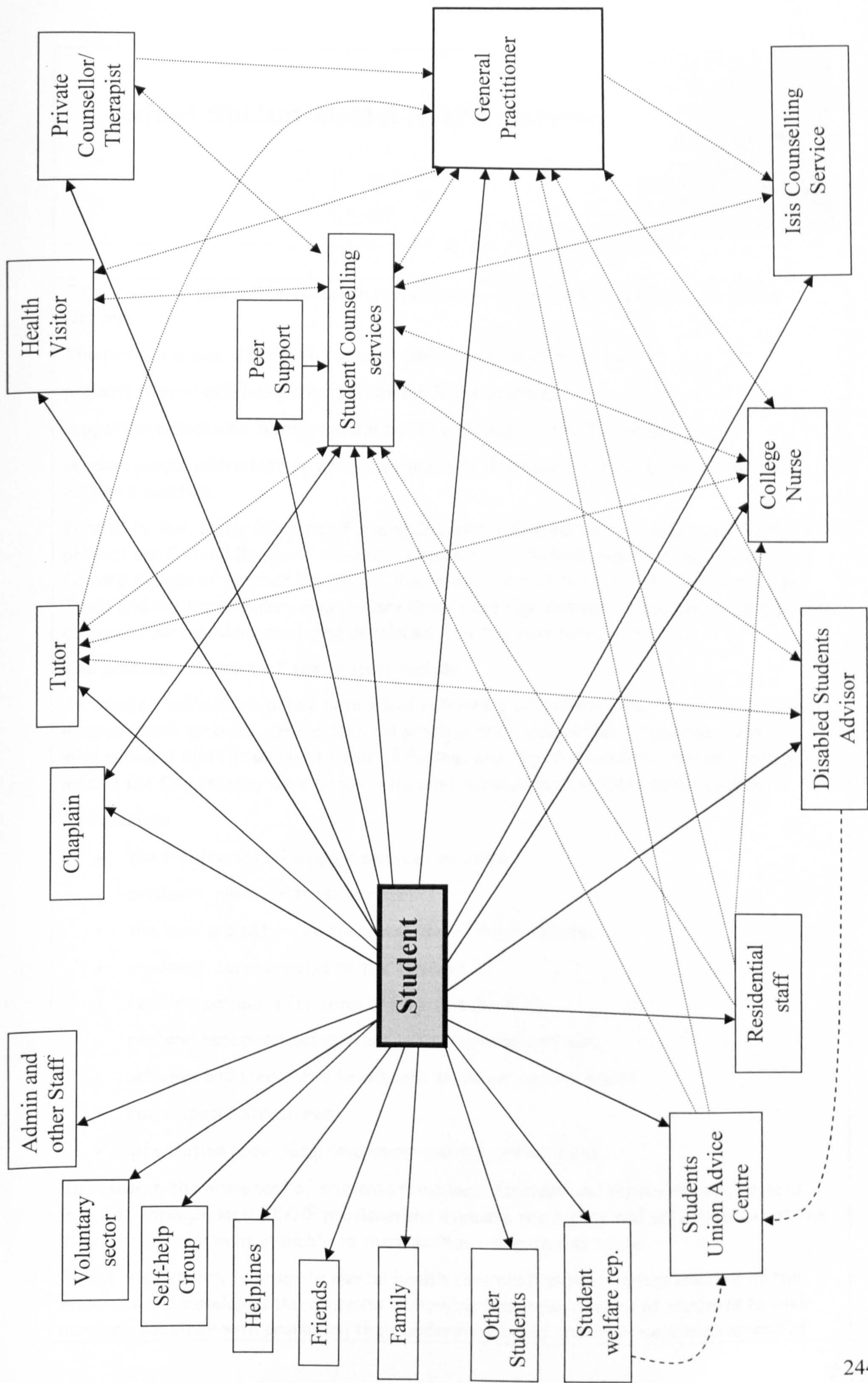
Students' mental health – open forum - Autumn 2002

Students' mental health – open forum – Spring 2003

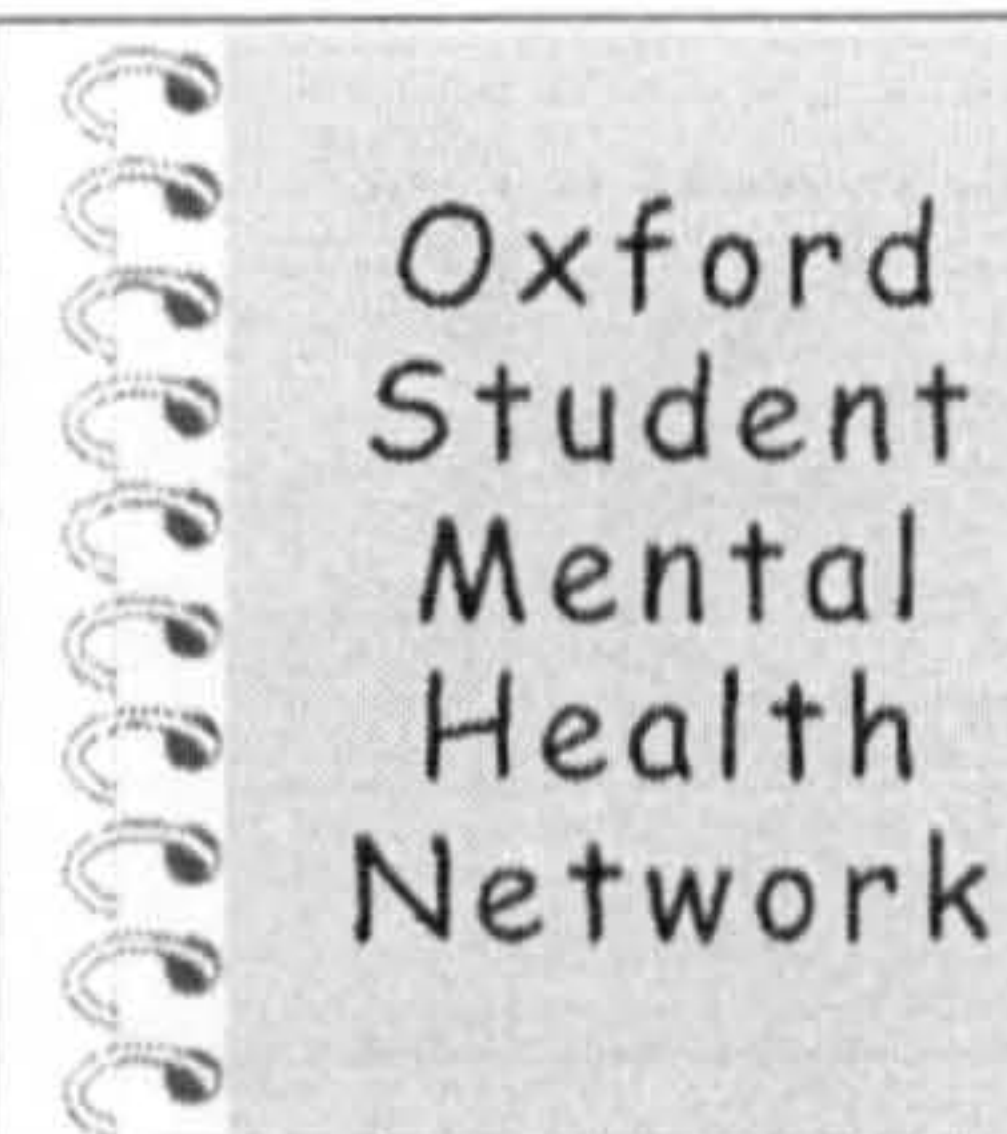
Appendix 1.13 Data categories used during analysis

<p>1. Types of mental and emotional problems mentioned Problems encountered, types and severity Are students more vulnerable than age group/general population? Is the situation getting worse? Existing problems New problems Relapses Comparisons between institutions</p> <p>2. Beliefs about causes of students' mental health problems/ Respondents defining mental health problems – what is a mental illness? Distinguishing between stress, emotional upset and illness Labelling Continuum or categories? Social, psychological and medical definitions Current stress – life situation – current events – low self-esteem - drink and drugs – economic factors Getting to university – sacrifices, pressures Family Vulnerability Personality - perfectionism Biology Psychological (various approaches) Emotional intelligence/ literacy Coping skills Isolation Vulnerable groups: women, mature, young, overseas, social class, gay</p> <p>3. Help-seeking behaviour MH problem acknowledged at all? Help sought at all? Help sought early enough? Different help sought for different problems? Social help Psychological help Medical help Self-help Multiple sources of help Views of help seeking</p> <p>4. Nature of support available Nature of services – approaches used Social support / Peer Support Psychological support Medical support Academic support Advice services Holding operations Evaluation of own service Confidentiality / information sharing</p> <p>5. Access and referral to respondent's service Referral into respondent's service Eligibility / suitability for support Waiting lists</p>	<p>6. Interagency issues Referral between services / sources of support Knowledge of how to access support Student choice Attitudes towards accessing different forms of support Evaluation of other services: <ul style="list-style-type: none"> • Adequate services? Good and poor practitioners • Gaps in services • Timing of services • Continuity of services Boundaries / Collaboration Rivalry / suspicion Demand for specialist student mental health service</p> <p>7. Institutional factors Identifying problems Identifying good practice Having policies and protocols Providing / accessing support Making reasonable adjustments – disability rights Disciplinary issues Health promoting – stress reducing activities – relapse prevention Confidentiality / information sharing Ability to cope with increased numbers of MHI students Support from academic, residential and service staff (non healthcare or counselling positions) Need for specialist MHI staff in HE and FE</p> <p>8. Academic factors 'Good' and 'poor' colleges Expectations Living arrangements Student life Effects on others Education as health-promoting /developmental activity Negative impact of course content or questioning of assumptions etc</p> <p>9. Personal roles Attitudes / Awareness Knowledge Skills / Training / Training needs Nature of relationship Boundaries Involvement Confidentiality</p> <p>10. Stigma and discrimination Attitudes of others Disclosure Unequal / unfair treatment Good practice</p>
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Potential pathways of support for students in Oxford with mental/emotional health problems up to GP level



Oxford Student Mental Health Network



This is a three year action research project focusing on student mental health issues in Oxford.

The project is concerned with research and development which will:

promote mental well-being amongst the student population

support students who develop mental health problems during their studies

support people with a history of mental health problems who are entering Further or Higher Education.

Funded by the Higher Education Funding Council for England, the academic partners in the project are Oxford Brookes University, University of Oxford, Westminster College and Oxford College of Further Education. Representatives of the NHS Mental Health Care Trust and the local Primary Health Care Groups are represented on the project's steering group and partnerships are being developed with the voluntary sector.

The planned outcomes of the project include:

To create a sustainable active network of relevant professional expertise from specialist mental health services, general medical practice and local specialist agencies, together with relevant staff from institutions of further and higher education, that will continue to inform the City Primary Care Group in its work in relation to student service users.

To research:

- the treatment and support services available
- students' need for these services
- the level and nature of students' use of these services
- students' access routes to the services
- referral pathways for treatment and at discharge
- real and perceived deficiencies in the services available
- schemes and structures to enhance students' mental health
- peer support structures
- information about local treatment and support services

To research the movement of students from local recovery and rehabilitation projects into, and through, local FE/HE provision and evaluate the quality and effectiveness of the support and treatment available to them as they navigate this route.

To use the network to promote mental health care professionals' understanding of the emotional and developmental contexts underlying the presentations of students to their services, together with promoting their understanding of the treatment implications of

the deadlines and structure of the academic year.

To use the increased inter-professional understanding created by the network and the outcomes of the research to move towards a more planned, coherent, accessible and cost effective provision of treatment and support services.

To use the network to share and promote best practice in prevention, treatment and support in the field of student mental health, including making use of the outcomes of work being undertaken by other student mental health projects in the UK and in the specialist field of support for international students.

To produce guidance and procedural materials (in print and electronic form) about local treatment and support services for the use of staff working in F/HE and for direct use by students.

To provide a model of inter-professional networking and collaboration in the field of student mental health, and associated with the new role of Primary Care Groups, that will be transferable to similar groupings of FE and HE across the UK.

The Oxford Student Mental Health Network employs a Researcher/ Co-ordinator and an Administrator. We are not able to offer direct support or advice to students, but aim to assist those organisations and services that are involved in supporting students with mental health problems.

Further information can be obtained from our website at

www.brookes.ac.uk/osmhn

July 2000

Appendix 3

Appendix 3.1 Identifying mental health problems

3.1.1 University of Oxford

Generally, JCR members are fairly sound but there are high levels of stress which leads to anxiety and you do see those who are panicking about exams who do not want to talk to their tutor or parents.

Student Welfare Representative OXU S03 13-15

I mainly become aware of issues through my friends who are either unhappy or incredibly stressed; stressed more than would be expected e.g. more than others in the same situation. In the JCR you get to know of friends and friends of friends with problems.

Student Welfare Representative OXU S04 6-9

I don't know whether I am just seeing more cases, or if there is an increase in the number of MH cases. I have seen more alcohol problems, and there seems to be more students with anorexia. The incidence of stress and depression is fairly even.

College Nurse OXU 010 149-152

I encounter the range from those needing low level support to someone who was a walking nightmare. This term [*Trinity*] is usually worse: those with underlying psychotic illness crumble, those with OCD [*Obsessive Compulsive Disorder*] get worse as do those with anxiety.

College Nurse OXU 010 12-15

Alcohol-related problems should really be addressed, it is a serious situation. There are more who are more or less dependent and have alcohol-related problems.

College Nurse OXU 010 161-162

You can do nothing with those who are severely mentally ill, the college gets at least one each year, but sometimes they are successful.

College Staff Member OXU 015 28-29

The present cases [of eating disorders] are those who are desperate to come along. There are 10 times more out there.

Counsellor OXU 009 85-86

There are roughly 10-15% of students that the College would be worried about. Some are a concern throughout their studies and need help throughout their time here.

College Staff Member OXU 019 23-24

There is an average of three students entering each year who cause concern and they pose problems throughout their time at college. With such students you know to ignore and watch and not react while they do certain things. They are always the last to do things that are required of them ...

There are nine to ten students at any one time who fit into this quite seriously disturbed category.

College Staff Member OXU 018 19-22, 24-25

I wouldn't like to think that more students were coming in with mental health problems as there are enough coming in already and that is stressful enough.

College Nurse OXU 010 153-154

I think the level of distress amongst [*postgraduate*] students [*in the college*] is about the same as in the population generally. We all have a certain amount of stress.

College Secretary OXU 021 84-85

Common problems are to do with drinking (men in particular). Sometimes eating disorders among the women students.

College Staff Member OXU 018 11-13

3.1.2 Oxford Brookes University

Both of the most difficult cases this year have been overseas students, who came with no advance warning of their problems. There were two who showed bizarre types of behaviours that others complained of.

The XXXXX [*nationality*] student has fortunately left, a relief as was coming up with bizarre things, paranoid statements, and was getting more and more bizarre, and was driving other students mad.

Hall of Residence Staff Member OXB 010 21-25

There have been a few cases, two out of touch with reality, others who are needy or problematic to work with.

Hall of Residence Staff Member OXB 011 9-11

Hall of Residence staff members don't really pick up the more depressed students, but sense that they are different to the other students.

Hall of Residence Staff Member OXB 012 38-39

One notable student self-harmed and would go catatonic, she would see things and people that were not there. One night she went running off to Headington in her pyjamas and I had to phone security to look for her.

Hall of Residence Staff Member OXB 013 21-25

I have had an attempted suicide (pills and alcohol and slashing wrists). The student had a history of mental illness and her doctors didn't think she would be able to be at University, she had been sectioned previously. This girl had problems from the past that she hadn't dealt with. She was a student who can't cope and this manifested in extreme behaviour.

Hall of Residence Staff Member OXB 013 10-14

Two or three people a year are seen to have problems, these can be a one off or can run on though the year.

Hall of Residence Staff Member OXB 013 9

There are 400 students in one of the Halls managed by me. At present there are three students that are causing worry due to their mental health state, but there is a further hard-core who are causing concern due to their behaviour (mainly alcohol related).

Hall Warden OXB 012 15-17

I have seen students with very high anxiety levels and getting depressed, through to some attempting suicide. You pick up problems through students exhibiting different behaviour from what they normally do.

For some it's just a month of depression which, if caught early enough, can be prevented from worsening. In a hall of 100 students, you might have five cases ranging from needing referral to counselling or the doctor to the more extreme where someone goes home or is hospitalised.

Hall of Residence Staff Member OXB 016 25-31

Every year I notice that there are three or four students with obvious mental problems, plus increasing aggressiveness amongst other students.

Hall of Residence Staff Member OXB 012 19-20

I have noticed a significant increase in mental health problems in the general student population. I see more cases coming up and see it as likely to increase further.

Hall of Residence Staff Member OXB 012 8-9

Aggressive behaviour is on the up, probably due to alcohol and drugs which are more available.

Hall of Residence Staff Member OXB 012 29-30

I have just become a warden again after a ten year break. I have noticed that students are definitely drinking more and there has been a big increase of this amongst the female students. Particularly worrying is the change in habits of international female students, now female students from the Far East are starting to behave like UK student drinkers.

Hall of Residence Staff Member OXB 014 47-50

Apart from stress other problems are not so obvious, others have volatile relationships or are on the brink, not aware of the common mental health problems. This *[Summer]* term has been feeling hard to me in terms of motivation. Students get caught up in academic life, which is not counterbalanced from outside. The anxieties and fatigue and lack of motivation are quite common and I have noticed them a lot both in myself and in others.

Student Representative OXB S01 38-42

At Brookes I was aware of a lot of problems amongst other students at the level of anxiety and stress to a mild extent, but was not aware to a great extent of more serious mental health problems, but from personal experience could see people that probably had personal MH problems.

Student OXB S03 9-12

3.1.3 Oxford College of Further Education

Anxiety, depression (as it is labelled but covers a range), insecurity, lack of confidence. I deal with these every day.

Tutor OFE 001 5-6

Mental health problems are getting more and more common. All life skill trainees have a degree of problems.

Tutor OFE 002 18-19

What causes most concern are the ones who are unusual. Experiencing things that staff haven't had experience of such as hearing voices etc. It is hard to know what information there is on this topic.

Tutor OFE 002 21-23

3.1.4 Oxford City Primary Care Trust

Personally, I would see about one or two students a year with psychotic illness. I am not sure how many are seen by the other partners but these few students tend to be regular attendees.

General Practitioner NHS 004 6-28

With students, the presentation of mental health is more intense and more immediate. I would say that students are more depressed and anxious than the rest of the population but their problems are more likely to be picked up. You don't see those problems which are not picked up.

General Practitioner NHS 002 12-15

The Practice does see a lot of students affected by alcohol and drugs. It is difficult to say whether numbers are higher amongst students compared to the same age range amongst the general population but the impression is that students do go wild for a bit during their first year. GPs have seen some students who have been disabled by alcohol use.

Eating disorders are over-represented in the student group. They are probably seen more among students than in an age-matched group. I don't have figures to show this but feel that this is the case.

General Practitioner NHS 004 38-45

3.1.5 Oxfordshire Mental Healthcare Trust

'Depression' is a wide term applying to a range of experiences and can be a way of medicalising life problems. I am therefore wary of this label. How can you cover severe clinical depression and being down in a single word?

Psychiatrist NHS 001 22-30

As a CBT specialist, I work within a continuum model of mental health and don't work within a traditional medical model.

Clinical Psychologist NHS 020 119-120

I use the developmental model of mental health. There is a need to judge whether the student is experiencing something in their normal range developmentally or whether the experience falls outside the norm.

Psychiatrist NHS 019 54-58

There are 25 students in the current caseload. They come and go but that number is probably fairly typical.

Psychiatrist NHS 006 14-15

Amongst the clients encountered here, I see lots of anxiety, also OCD, phobias, social anxiety, panic attacks, PTSD [*Post Traumatic Stress Disorder*], sleep problems, depression is a big one, low self-esteem, loneliness. There are quite a few people with a history of abuse, and eating disorders.

Clinical Psychologist NHS 020 123-125

Appendix 3.2 Beliefs about causes of mental health problems

3.2.1 University of Oxford

I see psychoses as a total regression to an early baby stage that appears as mad when acted out by adults... There is a need to be aware that the student age group can have these psychotic experiences without being schizophrenic.

Counsellor OXU 007 133, 138-140

I am also aware of my own mental health through combining my JCR duties with academic work which means I have little time to myself. It is a matter of keeping a balance, staying in control and trying to cope yourself.

Student Welfare Representative OXU S04 10-12

Past events which may occur may be around their family, expectations, or questioning their identities e.g. 'am I really gay?'.

Student representative OXU S04 34-35

There is no time to work through things at Oxford. My solution is to tell the student to take time out to think but students say 'I can't'. These observations are just based on the students I know.

Some students will come from families where you don't talk about feelings and problems.

Student representative OXU S04 112-116

The people who come to the University are those who take things seriously, and negative things do happen. People's insecurities can emerge, commonly 'I'm not intelligent enough to be here'. The media image doesn't live up to the reality of life at Oxford.

Student welfare officer OXU S02 41-44

In terms of presenting problems, there is a high level of anxiety due to the personality and the drive of high achievers, and secondly due to what is lost as a result of that e.g. socially and in other areas.

Student representative OXU S04 17-19

Perhaps the person is showing strange behaviour often linked to stress. The Oxford environment is very intense. It may be a personal situation that people have brought from home.

Student OXU S02 7-10

Complete exhaustion has a lot to do with it. This is partly because of the nature of 8 week terms. It gets to a point where sleep isn't enough. Students have a high level of awareness, they don't have breaks or enough time, 'no downtime'. Exhaustion results in terror and students may bring up issues from their past which they can't suppress. Perhaps they may turn to it as a reason for their distress or maybe they can't hold it back any more.

Student Representative OXU S04 28-33

There are all sorts of problems that students have to deal with: falling in and out of love, looking for future partners, concerns about future careers especially in some degrees where job security is not certain. When studying in a specialist area you are faced with 4 or 5 years of very hard work and might be unemployable or have to do something very different at the end of it. You can be passionate about your subject but it can wear off - will your motivation recover and will you be able to pay off your debts?

Student Welfare Officer OXU S06 114-119

I am conscious that some come from difficult home backgrounds and that makes a difference for some. They might explain to the tutor why they can't study at home and this gives an indication of what is going on.

Tutor OXU 020 60-62

High expectations impact and can put the pressure on them.

There are two with 'funny families'. How their insanity manifests itself could be pressure to succeed where parents failed owing to their illness.

College Staff Member OXU 018 68-70

There are a substantial minority in the university who are affected because of the way it is set up. In other places you are aware of ordinary life going on, here you in a tight little group living an unreal life you don't meet ordinary persons apart from me! Then students are plunged from academic into their family again for vacations.

Although the student has a sense of identity, they get here and it has gone. Some are fine others can't manage without the props of their family, but on going back home find they are different. Eventually people 'pan out' get an identity and parents accept them. At the end most will be OK but there are some who won't be.

College Staff Member OXU 015 52-59

There are lot more minor problems which are to do with homesickness and loneliness. It can be a big culture shock e.g. an African student finding Oxford mind-blowing.

There are also problems of adjustment for mature students who come back after being in employment.

Administrator OXU 021 36-40

There are problems of people feeling under pressure academically and high achievers who pressure themselves and are used to being top.

There is fear of exams.

Tutor OXU 020 11-13

You should also be aware of Graduate students who have different problems to undergraduates. For example Graduates from the States [USA] want a structured timetable which they don't get. They have to work it out for themselves. They have been expecting lessons, they expect the Quad to be buzzing with students all year round providing lots of stimulating company. They miss people taking an interest in them. Some waste or lose the first year as they are missing these things so much they don't get round to work.

College Staff Member OXU 018 88-96

Coming to Oxford has a bigger impact on students than I can understand. For those students who have not been to boarding schools and those who come from comprehensives it is a very big challenge. The trouble with being clever is that there is always someone cleverer. Students get anxious because they are no longer the stars they were at school. They are small fish in a big pool now.

Chaplain OXU 017 97-101

Levels of stress are higher amongst student now, but it is not all pathological. It is understandable as the job market is not very secure. Also the division of the 2nd Class degrees causes much anxiety. Most are in a dividing line between a 2.1 and a 2.2, and some jobs are contingent upon getting a 2.1 and so the level of stress and anxiety is increased. Often there is a legitimate anxiety related to this. Colleges are affected by the Norrington tables and their standing in the rankings, and so there is more scrutiny and Collections are more formal like exams. Undergraduates are generally happy to have standards kept up, but the pressure has caused a lot of concern.

Chaplain OXU 017 51-58

Looking at Freshers or even before they have started, the nature of people with anorexia is that they tend to be perfectionists and may aim for Oxbridge.

There are the students that end up here who are not always naturally bright but have worked hard to pass the exams and end up with anorexia or OCD.

And there are those that when they get here suffer from the divide between state and public schools. Those from state schools may be used to being the best in their group and now they are not. Also they find themselves confronted with students from the public schools who have a exterior polish and poise and have already boarded away from home. So those from the state schools can be anxious of encountering new things and find themselves comparing their situation with the privately educated lot. This causes quite a few to wobble. After a while it evens out. On the other side I have had Eton kids feeling insecure.

There is a lot riding on them, they are aware of the pride of their school and parents. On arrival they get the feeling that they are not the brightest and may not cope with the demands, but feel they can't go home. I will try to persuade them it is best to go back if you can't cope. This gives them an escape route, then they can get on with the business of settling in. I have had some students I have had to 'nursemaid' all the way through to their finals.

College Nurse OXU 010 72-89

At the risk of a massive over-generalisation, if they are used to using their intellect, it is a shock when it can't sort out their problem.

Quite a lot of students are successful in life. It is shock when they find something they can't manage. It assaults their sense of who they are. They have concepts that don't allow for messiness. It can be a shock to find that feelings can't be worked on like a tutorial. I say to them 'you are allowed to be messy'.

Counsellor OXU 011 28-33

I recognise the interconnection with the body, that an event can bring about chemical changes in the brain.

Counsellor OXU 007 134-135

What lies behind the clients' inability to deal with these problems by other means?

From the point of view of the my model I see the inability as resulting from deeply entrenched family issues and constructs which aren't constructive, constructs which are skewed in the next generation e.g. the belief that asking for help is a sign of weakness is derived from the parents being derogatory about counselling.

I find that some clients whilst knowing things are wrong at home, do not raise family issues with the counsellor because they see this as disloyal. This shows a lack of separation which is related to quite severe pathology in either parent which in turn arises from something which has not been addressed e.g. loss of a baby previously, and the sibling can convert this into their own distress.

Counsellor OXU 007 53-62

If the student has severe pathology e.g. self harm, bulimia or anorexia, it is nearly always the result of family relationships, especially between mother and girl.

Counsellor OXU 007 70-71

.... the university offers so much if you are confident with the environment and although the Counselling Service gets to see the 800 students who have problems we shouldn't forget the thousands who have a good time. But it is easy for students to go downhill with the start of low self-esteem and then depression.

Counsellor OXU 012 132-136

Those that come [for counselling] often feel uncomfortable in the social grouping they are in. I have seen many from working class or lower middle class families who are the first to get to university in their family, and they feel low in self-esteem compared to those who seem articulate and confident etc.

Counsellor OXU 012 65-68

Is it a lack of knowledge or a psychological block that causes study problems? It can be both. Some have not learnt the skills at school, some do not have a good tutor and just need straightforward information and some need counselling. About one third to a half of referrals are regular counselling clients. Of the study skills referrals, more than half come with intractable personal problems – they say that they have a study problem but actually have another deeper problem. There are those students who are perfectionists, for whom work is never good enough to submit and the procrastinators who can't get going. Procrastination is a major handicap for the student as an essay has to be completed each week.

Counsellor OXU 004 13-21

Most anorexic students tend to be very driven people. I would guess there are more eating disorders in any academic institution than outside for the same age group.

Counsellor OXU 009 59-60

Some are reluctant to face their own psychological make up. Some don't want to challenge their own view of their family e.g. one student said that their family is wonderful. However, many students still find parents a pressure. Parents can be impressed about having a son at Oxford. The students are also impressed to be there but there may also be a lot of rebellion and if the student can't leave then they may fail so there may be unconscious rebellion.

Counsellor OXU 004 53-58

It [an eating disorder] is a way of manifesting distress. It becomes addictive and the activity becomes entrenched despite the initial triggering stress diminishing. It is a matter of looking at the management of the addiction when stress arises in the future.

Counsellor OXU 009 77-79

They are completely overwhelmed and one thing known in Chinese medicine is that when you are out of balance you do more of that which unbalances you.

Perhaps the students are going around in circles. Perhaps they need an outside view. It may be someone not wanting to take responsibility, wanting someone else to sort it - a regressive step.

It may be about not wanting to admit vulnerability out there. There are confidentiality issues.

Perhaps they are not sure what it is about. They are not feeling well or happy but don't know why.

Counsellor OXU 016 97-105

3.2.2 Oxford Brookes University

Another factor is the lack of academic support. There is almost assumption before you start the course that you have X amount of knowledge, but those coming as mature students may not know about human biology and it is difficult to find someone to help you with this. You have to be badly stuck before you get support. Why do I have to wait until it is this bad?.

Student OXB S02 108-112

I have no more awareness than anyone, but see a lot of anxiety regarding academic pressures. As you talk to students you understand the financial pressure, family pressures, huge travelling times.

Student OXB S01 12-13

At the CFE it was just general anxiety and stress. As people had been out of education for some time, they were unsure of their academic skills, they had family responsibilities and financial pressures. The majority of people on access courses were aged over 30 so have those extra pressures.

Student OXB S03 20-23

Anxiety for different reasons, lack of academic support, change of personal situation, financial situation, there is a loss of focus for certain students. From observation of OT students there are issues around the course. It is bit of this and that, an introduction to the profession in which subjective information is given in lectures / seminars rather than hard and fast information. This leads to students questioning their judgement. Also placements are three steps backwards, in settings which are less innovative than the practice taught on the course. The combination of these factors leads to poor motivation and individuals questioning the validity of the study.

There can be a loss of motivation leading to anxiety. You are looking at your vocational future, so if you lose focus it leaves you with an empty space ahead of you.

Student OXB S02 5-14

Linked to the female student drinking is that some are becoming very flirtatious and you worry about their sexual behaviour and health. I have detected among the girl students that they are quite loose about their sexual standards and they may be feeling mentally insecure.

Hall of Residence Staff Member OXB 014 58-61

The causes may be behavioural such as the use of illegal drugs, increased drinking, it may due to the stresses - financial and others. Some students are arriving with emotional baggage.

Hall of Residence Staff OXB 012 10-12

The students are at a very vulnerable stage, they are not grown up and yet are expected to be grown up early on. They walk around as if they are coping with experiences and you can see it is a front and that they are anything but OK. In most cases if you suspect there is problem you are usually right.

Often they want someone to be kind to them. They may miss parents but won't admit it; 'don't tell anyone else'.

Hall of Residence Staff Member OXB 014 169-174

There is a pressure to succeed from family and from the course. What happens to those who fail or don't get a first grade? Undergraduates in 1st year can fail and have to come back and do it again and there are feelings of failure there.

Hall of Residence Staff Member OXB 016 215-218

There is a feeling that students should become adults when they get here but they leave their family and friends behind. Their home environment is a cage they fly out of and sometimes they hit the floor and we have to help them fly again.

Hall of Residence Staff Member OXB 016 226-228

I have been around since 1991 when I was a student. I feel that students are coming with more emotional luggage which they are finding difficult to leave behind e.g. financial pressures and the pressures from their family to succeed and hold down a part time job. These affect more students, not just home students but now far more international students who are without the support of family and friends.

Hall of Residence Staff Member OXB 016 7-11

I have noticed that clients often have had earlier emotional traumas which have not been resolved, e.g. death or divorce in their family. The trigger is beginning a new life as a student and experiencing loss as part of this.... A death is often not talked about with children and leaves their feeling about it incomplete. Something about being a student recapitulates earlier experiences and throws even mature students into something like the stages of adolescent development.

Counsellor OXB 003 63-70

[...] there is a hierarchy of those with a good upbringing who make relationships, who have positive experiences which they can draw on. There are other people who just find that the nitty-gritty of daily life is such a disadvantage to their development.

Counsellor OXB 007 133-135

There are also those clients you would expect, those with poor social skills etc.

The developmental stages and where they are at are significant. Are they going to stand the pains of the challenges that come at this stage?

Counsellor OXB 008 66-68

It often has a lot to do with a long standing issue linked to with present issues. It can be about how they feel about themselves and how they deal with issues, which goes a long way back. This can lead to secondary problems such as not making friends or not being able to talk things through. Some clients say 'I have always been like this'. For others there is something they want to deal with: it might be an academic issue such as exam failure or lack of motivation, it could be to do with relationships, maybe the student can't deal with their parents' divorce.

Counsellor OXB 006 46-52

Much emotional distress arises from the fact that the emotional environment is not conducive to mental well-being and there is not enough information or chances to think things through....

Counsellor OXB 002 192-194

The fragmentation of experience. The modular experience is inherently fragmentary. This view is informed by attachment theory which states that transition invites regression. Students need a good secure base e.g. family peer group, a type or course culture that is supportive... They need a culture of belonging which offers a secure base. A lot of students feel very insecure in the way things are configured. Intellectual confidence must grow out of security.

Counsellor OXB 007 126-132

When students present after a relationship break up. it could be 'I've fallen apart and can't do my work' and they may need a couple of sessions to prop them up. Alternatively the distress may be linked to some earlier loss, they may also be in an repeating pattern of relationship failure. People either come straight away or later when they feel they should have got over it but haven't.

Counsellor OXB 008 89-93

Those who went to very structured schools may find university life very hard. They may drift, perhaps having a good time but can't manage the learning side and end up at the counselling service in term 2 saying 'I can't manage'. They have been expected to manage this new phase even though they may not have had the chance to live in an ordinary family e.g. because of being at boarding school. Many manage, others, a minority, don't.

Counsellor OXB 008 98-103

What is happening more and more is that students need to be told that what they are going through is normal, a part of growing up, a separation from parents. The task is developing a separate identity but staying close to these people (parents) who you are still financially dependent on. There are also issues with partners, how to be close but stay as oneself. For student clients there is relief that this is understandable, that these are age appropriate questions and tasks.

Mature students face some sort of feeling of being vulnerable again. If they are married and are parents, they may struggle with how to be part of the university and part of the family at home.

Counsellor OXB 004 112-120

Their experience of higher educational may not be what they expected, and this has a knock on effect. A typical example is the female student with a working class background, who has had a relationship split up, and has come to University via an Access course. Then certain key people (e.g. the mother) get envious and the support vanishes, and now they find they are the enemy. And that is just one of many scenarios, their whole life is churned up and turbulent. On becoming a student people realise the energy that they have put in maintaining life e.g. the needs of a demanding aged parent. They no longer have the time now to both meet others' needs and to be a good student. They wonder 'are they bad' (selfish). They are a wonderful and interesting client group with anxieties to be contained either through brief intervention to or longer term work to regain a sense of self.

Students may get a run of sudden things happening, being confronted with ghosts from the past. Many come in with an unconscious agenda of addressing unfinished business from earlier experiences. They may come to find out why the world is the way it is. When they feel so different about themselves as a result of being at university, it is a chance to reconfigure everything. They come to redo their lives. People may come with dreadful previous experiences of earlier education and get re-stimulated distress.

Counsellor OXB 007 50-66

Family breakdown can be part of it. Some parents may split up when the student comes to university or sometimes distance from their family plays a part with students losing the safety net of home. A lot of international students are seen, they are unable to go home for a good meal and security when they feel like it.

Counsellor OXB 009 53-56

Sometimes they are worn out – both emotionally and physically. They lack the energy to problem solve or see the problem differently. Having a collaborator gives them energy.

Sometimes the nature of the problem is to do with the family and it is very private e.g. sexual abuse, parents marriage breaking-up, and they need confidentiality when talking it through.

Counsellor OXB 004 88-93

3.2.3 Oxford College of Further Education

[There are] incidences where students are affected by other family members' mental health problems. I previously worked with a student who was principal carer for her mother who had severe mental health problems. [There are also] issues associated with drugs and alcohol, eating disorders, sexuality, sexual abuse of and by students.

Tutor OFE 001 8-12

They are low achievers, young people who didn't take qualifications or who got low grades. or who failed. Many have social problems at home. There are those with learning needs, social needs, or both.

Tutor OFE 002 9-11

They are going through big life changes after leaving school. They have to be independent and fend for themselves. A small percentage live away from home. Those not at home are in housing schemes where there are often problems, so it is not ideal.

Tutor OFE 002 27-29

The whole nature of the trainees seen has changed. There are more severe social needs and problems with literacy and numeracy.

Tutor OFE 002 115-116

Part of growing up is thinking 'what can I do to make it better for me?' We should not view them as victimised. They get into I'm not OK and you're not OK. There was one student who drove people mad and she would just turn up expecting help, and I said 'I have had enough of you being a victim' I pointed a few things out as a gamble and but it did the trick. We had a session where we just looked at the positives, she didn't see her own role in the problem.

Adviser OFE 005 91-95

The young are egotistic and don't look outside. If you weren't parented well, you don't look outside but still cling on to the bad mummy, you still want the thing that wasn't there. If you have had good enough parenting you can let go, but others can't let go and are still looking for the bad mother.

Adviser OFE 005 96-99

3.2.4 Oxford City Primary Care Trust

I wouldn't concentrate on the eating disorder as the disorder but would see it as a symptom of something else e.g. earlier sexual abuse etc. Putting too much emphasis on weight and food would miss the point but, on the other hand, if you don't focus enough on it, you may lose them in the follow up. Those with binge eating disorders don't seem to be up front about their disorder.

General Practitioner NHS 002 31-35

A lot of depression is seen, partly as a result of reaction to the course, sometimes due to poor coping skills, sometimes due to family dynamics and partly due to genetics. So all of these can contribute.

General Practitioner NHS 002 7-9

Personality. Family circumstances....

I can't claim to understand psychotic illnesses (does anyone?) but am sure that it is a combination of pre-morbid factors and current factors. It can come out of the blue and there may not seem to be any precipitating factors but when you look back you may see that their personality differed from the norm e.g. loners.

Some students can be in denial that their problem is medical and could be addressed.

General Practitioner NHS 004 82, 88-92

We get a few schizophrenic students. When they are admitted there is something odd about them, especially if you take a neuro-biological view of schizophrenia and the possible links with high intelligence.

General Practitioner NHS 002 16-18

3.2.5 Oxfordshire Mental Healthcare Trust

The environment can be difficult for the more vulnerable student and is especially aggravated by the competitiveness of the system which can fragment the student group. From the outside, it would appear that university life is cosier but I feel that it can mimic sibling rivalry with the students all clamouring to be best.

Psychiatrist NHS 019 88-92

There is a typical example of a female second year student who is self-harming. Her boyfriend told her to approach the service, there were issues of dependency. The student may well have been abused in childhood. Students who self-harm are seen as difficult by the College due to anxieties surrounding self-harm and suicide and their effects on other students. The signs may be an indication of what may in later years be diagnosed as a borderline personality disorder.

Psychiatrist NHS 019 129-134

Most serious mental illness might have developed anyway regardless of being a student.

Psychiatrist NHS 003 14

... most of the students would have been ill anyway, regardless of whether they were at university due to the fact that most present with problems that began in adolescence. However I do question whether university doesn't help a person's mental health. University life does have its pressures.

Psychiatrist NHS 019 83-86

I would be cautious about the genetic or biological theory of causation. Whether it is true or not, it doesn't change what we would do now. Perhaps it is useful for the extremes of illness, but most clients are in the middle and are affected by many factors. I would note family history of mental illness but am careful with the interpretation of this.

Psychiatrist NHS 001 72-76

Other examples relate to first year young men who are having problems with their sexuality and are uncertain about their identity. They are struggling with the possibility of homosexuality and are fearful of the reactions of other people.

People also approach the service with depression. Life events such as bereavement which trigger depressive illness are fairly common. There is a question as to whether anti-depressants can help. I feel that they may provide limited help but do not provide the whole answer. Occasionally I see students with severe depression with suicidal ideation.

There is a paralysing anxiety surrounding students using alcohol and having relationship problems. This would go beyond what the counselling service feels that they could deal with and there would therefore be a need for medical referral. Anxiety states which go back to underlying family problems which are a result of more than just short term exam panic can also give rise to referrals.

Occasionally Bi-Polar Affective Disorder is raised as a possible diagnosis by counsellors but this is rarely confirmed. The student age group may have a tendency to swing between low and high moods, especially when alcohol is involved. Bi-Polar Affective Disorder is most often found when there is a family history of mental illness.

Psychiatrist NHS 019 135-151

There are a lot of vulnerable students at Oxford University. They have worked very hard to get their grades and haven't developed in other ways. Some of the staff at the University are not much better themselves and are no help to the students. Students need to be able to have fun as well as spend time studying and the 8 or 9 week term does not allow for this. However, some students do manage to pack a lot in.

Psychiatrist NHS 003 76-80

There is the effect of undergraduates leaving home, things to do with being a student.

Psychiatrist NHS 006 85

There is the pressure of getting good qualifications, whether you get a 2.1 or 2.2 seems very important at the time but is not so important later in life.

Being away from home can have an impact.

Anxiety over debt. This government has made things worse for students and some may be put off earning a wage at the end of their course because of the repayment of loans when they do start earning over a certain level.

They worry about what employment they will get after the course finishes.

Psychiatrist NHS 001 82-88

Appendix 3.3 Stigma

There is a stigma around mental health which is enormous.

Academic Staff Member OXU 023 220

People hear about the disruptive behaviour or potential violence associated with MH problems. If it occurs once then the college community becomes scared of all others with mental health problems.

Counsellor OXU 004 185-187

There is more media coverage if anything goes wrong.

Counsellor OXU 007 197

The students still have a fear that other people and tutors will find out and that they will be thought less of. They have a fear of not being able to cope and do not want the situation to be happening to them.

Administrator OXU 006 124-126

People are frightened of mental illness and strangeness. This is perhaps something which they do have a right to fear but there is a need to be aware that the danger element is only a small proportion.

Counsellor OXB 009 228-230

There are a few students who are the 'odd ones out' within the college. You can't do much to help them. It is human instinct to ridicule behaviour which is not 'normal' and to pick up on any exaggerated behaviour.

Student Representative OXU S05 83-85

Appendix 3.4 Stigma concerning use of services

There are those who don't want their problems known by those who surround them. They like the anonymity and do not want to be seen as weak by others, but can admit their fears to counsellors. Some experience the seeking of counselling as a stigma e.g. the embarrassment of seeing a fellow student in the CS waiting room. Others are blasé about it, there is a wide range of views.

Counsellor OXU 005 34-39

If someone from one college sees someone from the same college in the counselling service waiting room, there is embarrassment. Being seen as vulnerable at Oxford University is not acceptable. I have been working on vulnerability as part of the induction process at one College. I will ask freshers 'how many feel a fraud being here?'. The majority will put up their hands.

Counsellor OXU 007 176-180

I believe that there isn't a sense of stigma for most students in coming for help and they are quite open about it. Some students are ashamed that they are so weak that they have to approach the service but I believe that this is minimal. Some students are in psychologically difficult places and may be hard to work with but they are bold enough to approach the service. Others see it as beyond the pale to consult a counsellor.

Counsellor OXU 008 49-55

I would be concerned about the affect on their future profession. I wouldn't lightly document something that goes on to file for that reason.

Academic staff member OXU 020 141-142

3.4.1 Fears about getting a medical record

The fear of something going onto your medical record is a genuine issue e.g. attempted suicide makes life insurance very difficult to get. Ideally it is something which we would not want to make people aware of but on the other hand suppression of information is an area where we would be medically and legally vulnerable.

General Practitioner NHS 004 130-133

3.4.2 Good practice in overcoming the stigma of using services

Students will have issues of what will happen if their MH problem is raised. Borderline issues cause anxiety, people like certainty. Institution- wide ownership of widening access is required. There can be a fear of 'crazy people' but their craziness may make sense. The powerful thing in counselling is that, given time, what most people say makes sense. By being heard they start to listen.

Counsellor OXB 003 214-218

Perhaps more formalisation of the support systems would be needed, but there is a need to avoid stigmatisation.

Counsellor OXB 009 233-234

Students can receive a more personalised service but being seen out of the University in a quiet corner does nothing to help promote mental health. Instead it makes it something which has to be shut away in private. Could students be educated in a more preventative approach? Perhaps all students should be encouraged to visit a mental health centre as part of their induction and be encouraged to discuss their welfare?

Psychiatrist NHS 019 172-177

Appendix 3.5 Coping strategies and protective factors

Protective factors

I have a personal faith which has helped but am aware that this is a very personal thing and cannot be taught. One can only hope that others have it and that is very difficult because it is a very secular society.
Student OXU S06 109-111

For some there is the issue of attaching to the institution, this may be due to individual or organisational factors, some don't feel integrated. The difference between those with a well functioning family and those with lots of losses and disruption, will affect how they deal with this transition to university.
Counsellor OXB 008 55-59

I also see, later on, those who haven't made such supportive groups around them. You don't tend to hear about problems from those students who are socially integrated. They probably don't have so many problems.
Tutor OXU 020 54-56

For students away from home, their primary sources of help are not available e.g. family and friends.
General Practitioner NHS 004 70

Successful coping strategies

How do students look after themselves? It is different for different students. In my case I don't go out dining and partying.

Talking to friends plays a big part.

Trying to manage work is important e.g. essays.

Not getting too tired.

For students there is a stress class as well as massage and relaxation. Lots of students do this, there is also yoga. Some try meditation. Some go for walks escaping from the work.

Student OXU S04 78-86

Sport helps a lot of students release stress, e.g. jogging or going to the gym - balancing the mental with the physical. I find that if I can't go to the gym, I notice and miss it.

Student OXU S04 87-89

I was fortunate that I knew what I had to do to for myself - give myself a 'kick up the backside' and focus on one thing at a time.

Student OXB S01 42-44

There are a few sporty people who find that sports help. I have methods of stress relief through cycling / yoga / meditation / friends outside of the college environment. Those with family ties and commitments will have discussions with partners and families etc.

Student OXB S02 64-67

Unsuccessful coping strategies

They drink, smoke and take drugs a lot. They go out a lot. It is what everyone else seems to be doing so is hard to say no. I can say no but others can find it hard. These activities can be numbing - the easiest way out - to go out get drunk etc. then come back and crash out.

I am sure a lot do talk to their friends and some just go home to get away from everything.

Student OXB S03 78-83

Everyone goes out and gets drunk (male and female students). They go out and have a laugh. This does, though, have a knock on effect when they feel rough in a tutorial the next day.

Student OXU S04 90-92

The basic one is to avoid the problem by not talking about it. Some also try excessive partying, excessive drinking or throwing themselves excessively into their academic work.

Some will avoid other people. They do not want to hear that it would help to talk. They prefer to be in denial and they do survive.

Student representative OXU S06 95-98

There are different views about how to cope: those who get drunk, whether to limit your social life.

Student OXB S01 59-60

[What else has the student tried?] The student bar. In my own year, those without family commitments have the student bars and clubs to go to, also recreational drugs.... I have tried the 'night out rule' of not talking about assignments etc. when out for a drink, but other students came along and brought the topic round to college matters and that was how it progressed, so it can be difficult to get away from the stresses.

Student OXB S02 63-64, 68-70

Some have an avoidance tendency, 'it will go away' or 'I am not going to need help'.

Residential staff member OXB 016 214

What lies behind the clients' inability to deal with these [eating disorder] problems by other means?

Denial of the problem.

Counsellor OXU 009 28-29

Appendix 3.6 Views on seeking help

University of Oxford

I don't know how to change the mentality of students and hope they will realise for themselves. It may be that a student has had a bad experience with some of the welfare services and feels 'it did hurt and I don't want to go back'. A few can't rise above a painful experience and seek help elsewhere.

Student representative OXU S06 155-158

The atmosphere is very competitive and it would be difficult to show weakness. This is not said explicitly but it is picked up that this is what you have to achieve and that it will be hard. 'Stress is my responsibility, I've got to do this degree.' People don't want to feel they are bringing something inconsequential. Also they probably think it is for those with serious problems and will underestimate their own problems, People here are used to being independent and doing well by themselves.

Student welfare officer OXU S01 94-99

I don't think that people would talk about accessing external support, they do things on their own when it gets serious.

Student representative OXU S05 160-161

A lot will talk to friends in College and would prefer not to talk to the welfare officer.

A lot that is going on is a good network. It is a friendly College, there is always someone to talk to.

Only when it gets to the point that you are looking for something else, not friends, are other sources of support sought.

I am not aware of students going outside the College for support (but this doesn't mean that it doesn't happen).

In general it would take a big problem to make someone go to the Counselling Service. There is a lot of feeling that students will solve problems themselves, a lot use friends, a lot use no-one, some use the welfare officer.

Student welfare officer OXU S01 84-93

I have also seen those who are feeling suicidal, but of those who are very upset, some wouldn't approach a welfare officer. They would feel it more appropriate to approach a closer friend.

Student welfare officer OXU S03 28-30

Often people who have academic problems do not want to talk to their tutor.

A few students see the chaplain for a life sorting chat.

Student welfare officer OXU S03 61-62

Either they haven't got others to talk to or those friends that they do have are rather intimidating to them e.g. those who are more outgoing and involved. If it is a work issue, it is hard to admit this to someone who seems more competent.

Student welfare officer OXU S03 75-77

Some need the confidentiality of Welfare Officers rather than friends.

If someone is depressed the Welfare Officer is the first port of call, not the friends. If they do approach friends first, they are more likely to approach a counsellor after, rather than the Welfare Officer.

Student welfare officer OXU S03 78-81

One trigger for the student approaching other support could be due to my inability to provide the student with any more time and me finding myself going over the same thing again and again with the student.

Sometimes a student can't tell me something because s/he is a friend.

People will suggest that the student gets help when they have scared themselves e.g. after suicidal thoughts but the student's situation has to get quite bad before they will talk to someone.

Student representative OXU S04 67-73

Sometimes families step in e.g. I talk to my mum about things, and people often go home for a weekend break for home cooking and mum. However, a lot live too far away, if you live beyond London, it is too far for a weekend. This is a problem especially for international students.

Student representative OXU S04 93-96

People e-mail friends quite a lot and that can help e.g. for overseas students who want to stay in touch with their friends.

Student representative OXU S04 97-98

Some students will talk a bit to tutors.

Students can go to the college nurse and the college doctor. I don't know how many approach their GP.

Student representative OXU S04 207-209

People don't talk to the Chaplain, except a few Christians.

Student representative OXU S04 212

In terms of presenting problems, you see relationship and emotional issues and the ending of romantic relationships. Other problems are as a result of academic work and frustration with such issues. You need a friend to help you get through that.

Student representative OXU S05 36-38

It is much easier to talk to a stranger than to sit down and talk about certain personal issues with someone who knows you. Part of your self respect is to promote a healthy picture of yourself to friends, not to show all the eyesores that only you can see on the inside.

Student representative OXU S05 86-89

For some, just silence could be the cure, time to get through their problems. Some don't want to take drugs or seek counselling and the reasons for this could be down to self esteem and a belief that it would be demeaning to do so. I for instance personally would not want to try either of those things.

Student representative OXU S05 90-93

Normally students prefer to talk to someone they know, some students won't go to official welfare officers if they don't know them. This is because they are unsure as to whether they can be trusted to keep information confidential, 'can this person be trusted not to tell their friends about me?'. In these cases, they will go to their friends who may or may not know what to do.

Student welfare officer OXU S06 224-227

In college, students are allocated to a particular doctor and it is a discrepancy in Oxford that students don't have any choice.

Student OXU S03 172-173

Choice is important as people have preferences for different types of people or different approaches to therapy. I would prefer CBT rather than a Freudian approach. I would want to have a choice.

Student OXB S06 194-196

Students would go to GPs first rather than counselling as they have heard of the modern antidepressants as a 'quick fix' for their problems. Counselling is associated with talking about yourself and many think 'this is not for me'. Those who have ended up at the counselling service are those who have heard positive things about it.

Student OXU S06 261-264

The student tried the counselling service but was not happy with it and preferred to talk to me. I agreed but warned her 'I am not a professional'.

Student welfare officer OXU S06 70-71

When I was depressed I self-diagnosed and went to see the GP and asked to see a psychiatrist as that is what you do in my home country. The GP advised against this as it would go on the records and this put me off and the GP explained it was not appropriate. I was concerned about the confidentiality - what if I apply for a job and this appears? But you have to face the fact that the system is not perfect and not allow it to put you off. People have been put off and are aware it will have an effect. They receive comments from their supervisor and choose to ignore them. You have to realise it for yourself and can't speak for others who feel attacked for being treated for depression. What you decide to do is up to the individual.

Student welfare officer OXU S06 280-287

Overall, welfare systems rely upon volunteers who have to work to get a degree. GPs can only spend a little time talking and instead give you medication, and counselling support is limited and tied to a framework. So the reality is you have to help yourself by accessing all the sources of support available and seeing which one works for you.

Student welfare officer OXU S06 315-318

My feeling is that students may overestimate or underestimate the degree to which they are in mental trouble. If they do talk to you they really are in trouble as they have each other to go to for tea and sympathy. However modestly they present the problem they are pleased if you take it seriously and that is why it is important to err on the side of caution and take their problem seriously. Sometimes students may present one issue and bring up another serious issue afterwards.

Tutor OXU 023 37-42

The situation varies, normally they come to me rather than vice versa. Some may tell me all about a problem at the time, others may tell it little by little.

I had a student with genuine depression but didn't know about this person's problem. She had rushed off home, she had been receiving treatment for over a year and it was not a crisis. It was useful to know what was going on and the student herself feels happier now that I know, but she didn't want people to think badly of her or be treated specially which is why she hadn't raised it before.

Tutor OXU 020 18-24

I have not encountered any resistance to the suggestion that a student needs help. Perhaps American sitcoms etc. have demystified counselling in a helpful way. The younger generation are more informed whereas I would have felt accused of being mad if that suggestion was made when I was a student.

Tutor OXU 023 190-193

The problem is persuading students to do something about their problems.

College staff member OXU 019 121

Individually I am sure that a lot will go to the chaplain but a lot won't.

College staff member OXU 015 16

People will chat to the Dean but not to the President, but some slip through the net.

No one has a wand to make everything all right. There are some students who go against themselves.

College staff member OXU 015 18-21

I know that students have gone to the Counselling Service. Some have been helped and some haven't connected with what is offered. Given the diversity of students there will be different approaches sought. Some go to the College Doctor or Nurse. I say to students that he sees people in confidence, but as he is on the Governing Body some students may be put off by this.

Chaplain OXU 017 118-122

In the first 2 or 3 weeks I have a constant stream of students through the door and then they get into their own support groups and it quietens down.

College staff member OXU 021 61-62

Some, probably many, form close and supportive friendships and that is where they sort out their problems.

Tutor OXU 020 49-50

Students who have used the counselling have appreciated that the counsellors are nice and non-judgmental. They would keep MH problems quiet from friends except perhaps in the case of exam phobia.

Tutor OXU 020 44-46

The students talk a lot about the support they receive from friends e.g. there was one student in my tutorial yesterday who apologised for yawning so much. She had been contacted at 3am by a friend in distress and had stayed with her until 8am.

Tutor OXU 023 56-58

After your friend or boss, the nurse or doctor may be seen as the first person who you can safely talk to about your problems in confidence.

College Nurse OXU 010b 156-157

Sometimes a friend or the administration staff will persuade students to approach the nurse.

College Nurse OXU 010b 150-151

A gap of two weekends is huge for students and many will start to push for an earlier appointment. It is at this stage that their anxiety can set in. A wait of more than ten days is too long for many. Fridays are an especially busy time for the service because the students have the weekend stretching ahead of them.

Administrator OXU 006 42-46

If people with reactive issues were put off coming to Counselling because it was seen as a MH service, they would get served elsewhere, there are many like this anyway. There is concern for those most at risk. It would be a disaster if those at that other end wouldn't come for support. It wouldn't be a change

in ethos to see people with chronic depression, severe anxiety, obsessive compulsive disorder, serious eating disorders and those who are suicidally depressed.

Counsellor OXU 005 209-214

As a counsellor it is nice when you get a balance with those who are coming apologetically with mild to moderate depression over a long time, and equally those with momentary episode of poor health. Because people at Oxford are articulate and think things through, they don't come to counselling on a whim.

Counsellor OXU 005 215-218

They are just puzzled, perhaps they can't sleep or are bursting into tears, they have thought and thought and can't make sense of it, so they want an expert to tell them the answer.

More commonly it has been going on for some time, those who had problems over a long time may be looking forward to a new start and then it still isn't OK, so sense 'I must do something about it'.

'I was bright and bullied at school – now it should be all right.'

'Now I can get away from the rows at home.'

There are also those who had a great time before coming to university and have plummeted since.

Counsellor OXU 005 43-52

I think that counselling is becoming more accepted, students come on the recommendations of others who have experienced it. Could look at it that clients seen are those who can cope and that this is their way of doing it. Also the American model of 'I'd better check in with my counsellor' i.e. the counsellor as one of the necessary accessories of student life.

Counsellor OXU 005 53-57

Some students would differentiate between the Peer Support and the Counselling Service and may go to PS first and will get referred to the CS, and that works well because then the CS is known and this is demystifying. Some don't expect to get referred and then they do and that can be tricky.

Counsellor OXU 013 33-36

What else has the client tried?

Various: friends, family, GP's, tutors, residential staff, Peer Support.

Counsellor OXU 003 77-78

In assessment I will always ask what has motivated the student to come now. Usually an event is the trigger e.g. bereavement or relationship breakdown. How much they are in denial influences how much they are triggered. Alternatively it seems purely internal, they have got overwhelmed by their feelings, and may be contemplating self harm or have a fear of suicide. These feelings get to the point that drives them to counselling for help. Some may just be coming up to exams and find that they can't work. If they say that friends have recommended them to come, they are usually in a healthier position than others, because they have been talking things through with others. However, if they are in denial, they may be at a crisis level when they come to counselling.

Counsellor OXU 003 82-91

In my previous work at a newer University, I found that more Art and Social Sciences students would present for counselling than those from Sciences, Law and Business studies. Psychology and sociology students would see less stigmas in admitting to needing support. Arts students may precipitate breakdown through their creative exploration of the unconscious. In the Law and Business Schools, when students did present for counselling, their problems were longer-term, having developed into a more serious nature through not having been addressed sooner.

Counsellor OXU 003 91-98

Some have tried other means of support, others have not. The counselling service is known to some students and therefore some come straight to the service. Others go through friends, the college chaplain, nurse or GP. Referral from Nightline or the Samaritans is rare.

Some students do not want to approach the service but in some cases the college or tutor who referred them tells the student that they must come.

Counsellor OXU 004 39-44

Counselling is much more acceptable now. There are perhaps some science students who are reluctant to talk about their past, they just want a problem to work on. In these cases I may run a one off study skills session and may use cognitive and behavioural techniques. I work mainly using these techniques anyway. However, some students may not want that. It is dangerous to generalise - there are also arts students who find it difficult to deal with emotion.

Counsellor OXU 004 45-50

There are others who don't want or need counselling but who benefit from assessment and reassurance that they are doing the right things. Some come because they are not getting reassurance from their tutor. Some are referred.

Counsellor OXU 005 26-28

It is quite common for clients to say 'its the last resort' or 'I've tried everything else'. They have used the GP, college nurse, friends and they say 'why don't you try counselling?'.

Counsellor OXU 005 31-32

The majority of clients refer themselves for counselling and the fact that they are seeking counselling suggests a severe position and so their problems are rarely trivial.

I feel that all referrals are appropriate even at the lesser end of severity, but in some cases the clients themselves may feel that they are perhaps not in need or deserving enough of help. I feel that the client's presence is always valid.

Counsellor OXU 007 26-31

The clients have normally approached their GP first. Occasionally they may have had other therapists in the past e.g. at school, but this is unusual. Three or four times a year the counselling service might get a referral from someone who has been treating the student before entry to university.

Clients are usually referred or have had the suggestion made to them by their GP, tutor and/or boyfriends e.g. sometimes female students are literally led in by hand. Sometimes they will approach the service at the suggestion of a friend who has had good experience of counselling, or it can be through a member of a peer support group. A small minority come by self identification.

Counsellor OXU 007 34-42

There is a marginal stigma attached to seeking counselling, a corollary of that is when they do come they do mean business and they don't approach the service lightly. Part of the first (assessment) counselling session is to deal with the anxiety of being in counselling. It is an unfamiliar situation to most. They will ask 'Am I weird?' 'Or pathetic?' 'Am I being selfish or self indulgent?'. These are all defences against their problem. They will lump counselling and psychiatry together and may ask me about this. They also ask about medication and I have to explain that this is not part of my role. Some ask about the model being used 'Is it Freudian?'.

Counsellor OXU 007 43-51

The majority of clients refer themselves to the CS.

Counsellor OXU 008 43

I have had one or two male students only. Bulimic students may be starving but are not under weight. Most anorexics are also bulimic. Most have tried other things, many have been in inpatient units, and have been prescribed anti-depressants. Some have had a lot of treatment from GPs, some have no help at all. Some come as a first resort to me. For many it is a last resort, they have had every sort of inpatient treatment and are still severely ill.

This group is more separate so not worried about the stigma of getting help.

Counsellor OXU 009 19-25

A lot of students have gone to people in their college or the college doctor, some have had previous counselling therapy, a lot have tried the Internet for advice on their problem. I am just noticing how many people are accessing the Internet as a source of support e.g. chat-rooms for particular problems.

It is reasonably common for the students to have tried other things first, because of fear of being seen as a failure. They can have a sense that they should have been able to sort it out intellectually.

Counsellor OXU 011 18-24

People don't come unless something is affecting them. The fact that they have not seen their tutor is significant, this is often down to confidentiality. They may have a preference for a person not in their college. Colleges' understanding of confidentiality is woolly and information can be shared between staff. You hear this too often that a student told one member of staff and found that another had got to know about it. They are trying to be helpful but it is off-putting.

Counsellor OXU 012 22-27

One or two have tried something else, but on the whole they have not. Some have had counselling or psychological support at school. Occasionally they have done alternative therapies and then come to counselling.

I am amazed how often I see kids who have used their academic ability as defence and then this evaporates as they are not the brightest once at university, and then the stuff comes to the surface.

Counsellor OXU 012 44-49

Some feel shame or embarrassment about coming for counselling, but it is mixed. One girl student was made to come by a friend, she put it off for weeks. They frequently say 'my parents wouldn't believe I have come for counselling'. Some hide it from their friends. One said 'I feel a failure, I feel weak being here'.

It is getting more acceptable over the years. One or two clients fear that it is the first rung to involvement with psychiatry or to admitting to being psychiatrically ill. When needing a second opinion I have found that it is less upsetting for the student to say 'I think you should see our medical consultant who is a psychiatrist', rather than 'I think you should see our psychiatrist'.

Counsellor OXU 012 50-58

Those that come often feel uncomfortable in the social grouping they are in. I have seen many from working class or lower middle class families who are the first to go to university in their family, and they feel low in self esteem compared to those who seem articulate and confident etc.

Counsellor OXU 012 66-68

If the student has a friend who has found counselling helpful then it is much more acceptable for them to try it.

If the decision to try counselling is made by the student themselves, it is more promising than if counselling is suggested by their faculty or tutor. It does not seem so bad if the GP suggests counselling.

The stigma is less if a friend has tried counselling.

Counsellor OXU 016 68-72

Male students especially are sensitive of the stigma, of needing to admit vulnerability. It is a big thing to admit at that age, but can also lead to a great sense of relief.

Male students may be surprised that they can be in touch with feelings, they may want to recreate dependency but find problems with settling in.

I see a lot of male students, it may be easier for the younger ones because more is being written about men and their feelings, whereas the students near their thirties may be less aware of this. For men it can be to do with the complexities of forming relationships. What is their role with feisty young women of which there are many in Oxford?

There was the male tutor who made it clear that he had had counselling in the past and thus made it possible for one of his students to come to the service.

Counsellor OXU 016 72-83

There is a mixture of those who have tired-out their friends and overloaded them, and those others who have bottled it up. Or they have tried to tell and it couldn't be heard. Oxford is very pressured. It affects friendships 'I can't burden them as they have exams'.

Counsellor OXU 016 84-87

Oxford Brookes University

I don't have a problem about talking about my experiences, but I know a lot of people are reluctant to admit it and it took me a long time to get where I am now.

Student OXB S03 100-101

A lot of students feel quite intimidated, shy and nervous of speaking out if they don't understand things in the course.

Student OXB S02 135-136

At Brookes people find it hard to disclose as they don't know how people will judge them and if they will be accepted, and are perhaps not even admitting the problem to themselves even if others have noticed.

With tutors and lecturers students have a feeling that they won't understand, so they don't go down that route.

Student OXB S03 27-31

I felt I probably waited too long in getting support as I thought I could deal with it my self. I have a friend with clinical depression, who recommended a private counsellor. This counsellor is also a trained psychiatric nurse.

Student OXB S06 85-87

Just having someone who had experienced something similar and knew what it was could help. By approaching me they felt they could help by not going behind their friend's back to see a professional.

Student OXB S03 17-19

I don't know anyone who has tried to access counselling. It is not such a bad thing to say in the professional culture that you have. I couldn't access counselling in my first year as there was a waiting list. I had financial concerns and went to the CAB instead.

Student representative OXB S01 55-58

Students may prefer going to someone they don't know for personal problems whereas if for academic issues it would be within their institution. It might depend on the nature of the problem and their own insight or whether they are attributing the problem to external factors.

Student OXB S02 137-140

If they do share information on their problems they share it with the people they share a house with. People think that they will be judged by their MH problem. If they experience it for the first time at university it is harder to talk about than if you had it before you came. You can accept and come to terms with it if it has been going on for some time.

Student OXB S03 32-36

At the CFE, I was really open to staff about having a MH problem. I was on a lot of medication and as I was relatively ill, I didn't want people to think that was about them. I didn't tell the other students, but did tell the tutors to make them aware as it was a big part of my life and because the medication affects length of concentration etc. The tutor were quite good, I guess, but as I knew about my health situation I didn't seek help, I just told them about it because of the effects on the work.

The situation was pretty much the same at Brookes. Throughout the three years I was open with my personal tutor as I went through some profound peaks and troughs which I couldn't work with to the best of my ability.

I didn't go to the tutor for advice but to say 'I will have problems finishing this piece of work will you send a note round?'. I had the same tutor throughout the course.

Student OXB S03 37-47

I don't know if people used the counselling services, it wasn't talked about. It may be that only the users' close friends would know. Support seemed to be more about using friends and being empathised with. However, other people who have not experienced the full extent of a mental health problem can think that it is just like when they are feeling down, so they may not offer appropriate support or advice.

Student OXB S03 48-52

All the support I have used has been based outside the university. I carried on seeing the psychotherapist from the hospital, following in-patient treatment, and then support from my mother as I lived in Oxford already and have stayed here. My personal tutor did occasionally recommend going to see a university counsellor when I said that something had happened. However, I wasn't interested as I had been through it so many times and they couldn't help to the extent that I needed.

Student OXB S03 53-58

The department recommended that I see the School's counsellor, but I felt unwilling to do this, partly because I was aware of at least 10 other students on the course who might also be seeking the counsellor's services and so the counsellor would be very busy, but also I am very fed up with the university and didn't feel like using the institution's services.

Student OXB S06 80-84

I have found with fellow students they were so fed up too, that you had 'bitch sessions' with them. Knowing this I felt unwilling to impose on student friends who also had so many problems. Also, with my own situation as an older student, I don't want to put my problems onto younger students for role modelling reasons and also in order to preserve their optimism.

Student OXB S06 88-92

I took my own course of action in seeing a private therapist.

Student OXB S06 95

My private counsellor suggested medication when I had a very bad month and felt suicidal, but I got myself out of the black hole more out of concern for the effect on my spouse than anything else.

Student OXB S06 99-101

As I am so disillusioned with the university, I would continue to seek external counselling in the future. There is a fear that that internal counsellors would want to deal with me as part of the university.

Student OXB S06 166-168

[If you were to experience similar problems again who would you approach for support?]

I would go to a [external] counsellor sooner.

Who would I talk to in the university? I am thinking about approaching a particular teacher to be my tutor, it would be nice to know someone was there.

Student OXB S06 175-177

You could say that the severity of depression, anxiety or eating problem is worse than others, and that is why they can't cope in other ways.

Counsellor OXB 004 96-97

Some people can be won over by the offer of seeing a counsellor so that they can get a certificate explaining the impact of their problem on their academic work. Others will say 'no I'm too hard' (the 'East End lad' image).

Residential staff member OXB 011 73-75

The depressed people are less willing to get help, whereas anxious people are more willing.

Residential staff member OXB 011 81-82

Some students don't take up the offer of counselling.

Residential staff member OXB 012 123

In the case of the female student, the father is very supportive and staff know that he could be contacted for additional advice on how to help her. She welcomed the chance to talk about the bereavement and I would go up to her kitchen, while she was cooking, for a chat. In contrast the male student didn't want to talk about it, I offered access to the counselling service but he didn't want that either.

Residential staff member OXB 014 30-34

People are unwilling to seek professional counselling and fear that that they will get a label attached to them and they won't go, especially male students. This is to do with a butch macho image. So if you come across a male student with mental health problems it is difficult to know how to approach them as they may not want professional help.

Residential staff member OXB 014 95-98

The students are at a very vulnerable stage, they are not grown up and yet are expected to be grown up early on. They walk around as if they are coping with experiences and you can see it is a front and that they are anything but OK. In most cases if you suspect there is problem you are usually right.

Often they want someone to be kind to them. They may miss parents but won't admit it; 'don't tell anyone else'.

Residential staff member OXB 014 169-174

Perhaps this is due to a lack of knowledge about counselling and psychotherapy, especially for international students who perhaps don't have that intermediate system, 'my parents would think I have gone crazy'. (Chinese student)

Just because you are seeing a psychiatrist or psychologist doesn't mean the worst, they deal with degrees of illness, but students assume they will be stereotyped. They need to be educated that psychiatrists can deal with the less severe issues too.

Residential staff member OXB 016 42-47

There has to be a balance between not intruding on a student's privacy and those who don't want others to know about their problems e.g. there are mature students who don't want private issues mixed up with university issues.

Residential staff member OXB 016 223-225

Counselling is not the answer for most students, they see it as the last resort.

Residential staff member OXB 016 148

Students tend to see counselling as a weakness, but I will encourage them to seek help e.g. the distressed student with a mother who is ill.

Residential staff member OXB 010 83-84

A lot of students don't like counselling but they do like someone to talk to. I have to be clear about my boundaries and the need to be saying what else you can do.

Residential staff member OXB 011 69-70

A common worry for the student is 'will it go on my records?'. Some more senior nursing students will go to see other counsellors since I am a nurse. Others have approached me but have stated that this is a worry for them. I keep notes for my own use only, but students are still worried that it will come up when they go for a job. However, it goes only on their medical records if they consult a GP.

Perhaps because of this concern, some students may leave it longer before coming for support. However, once the problem starts interfering with their life they do come forward. Some problems such as self-harm may never be seen by anyone as they can be well hidden.

Counsellor OXB 009 200-209

A lot have tried ignoring it and hoping it will go away – 'I should have come last term'. Some will have talked to friends or family and some won't, depending on the nature of the relationship or the nature of the problem. Some have gone to the GP first. The student may have gone to their personal tutor, not for them to solve the problem, but for advice on finding a route to getting it sorted out. So I find the 'why now' question is interesting to ask. Those students who have had counselling in the past will turn to it more readily. There is a perception that the problem must reach a certain level to be worth dealing with. Some students could benefit from earlier intervention.

There are those (especially men) who tried to deal with their problems by getting drunk.

Counsellor OXB 008 37-45

Some who come for counselling could deal with the problem by other means but choose counselling. The divide is between those clients who can talk about their emotions readily and come sooner, whilst there are others who can't and come rather late. Many who come have a mature attitude to using the service. they will use this service for a emotional problem like they would consult a GP for a physical problem.

Counsellor OXB 008 51-55

Young people may have anxieties surrounding relationships and that brings them forward. They may feel that they have burdened their friends enough or that their friends are fed up with them. The students are brought in by issues which are beyond that which they can cope with.

Sometimes the students will realise that they need to sort things out e.g. if they have been over drinking over a long period.

Counsellor OXB 009 57-62

Sometimes students have a perceived lack of support. I am aware that as a tutor [dual role – also counsellor] I need to make myself available to students but some tutees never make themselves known to their tutors. I know that other tutors can be available but the students are not taking up the opportunities.

Counsellor OXB 009 63-66

Sometimes students may have a sense of urgency for counselling, coming forward following a catastrophe of some kind. For example they feel bad on a Friday and may be given an appointment for the following Monday but don't turn up maybe because the catastrophe has passed over. There is a need for research into the reason why people sometimes don't take up their first appointment.

Counsellor OXB 009 67-71

A lot of international students are seen, they are unable go home for a good meal and security when they feel like it.

Counsellor OXB 009 55-56

International students will often present with advice issues but underlying issues requiring counselling may subsequently emerge such as a bereavement which has had a significant personal impact. Similarly, sometimes students present themselves for counselling but actually need advice. Whereas the professional may be aware of the differences between advice and counselling, the international student's previous experience of getting support may be very different and therefore some clients may be confused and unsure what the distinction is between the two.

Counsellor OXB 002 12-18

In the case of international students, the people they normally approach are no longer accessible, especially, for example, in the case of family members. In some cases the students have tried approaching staff but have found that they have either not been helped enough or not helped at all. Many have tried residential staff and again their experiences with such staff have been mixed.

Counsellor OXB 002 58-62

Some nationalities tend to remain in their national groups. This can help but can also be difficult for some students. In the more collectivist cultures, students who are starting to operate outside the norms find it hard to seek support from that group. As students, they may be affected by new codes of behaviour and see it as a chance to move beyond the confines of their original culture. They may provide each other with practical support but are reluctant to disclose things of a more personal nature within the group.

Counsellor OXB 002 63-68

Some international students may not be used to seeking professional help. They may be looking for a way of presenting their problems without losing face as to do so may be unacceptable within their culture. There are many different cultural views on mental health e.g. a West African may somatise distress e.g. a headache for depression. There is a need to understand the concepts and language that could indicate distress within the different cultures and there is a need to find a mode of communication for students to convey their feelings.

Counsellor OXB 002 69-75

Some students have approached their GP for psychiatric referral at the same time as accessing counselling and subsequently they may get their assessment whilst still seeing a counsellor.

Counsellor OXB 002 141-143

There is an example of one student who had borderline mental illness features but was not assessed as dangerous to others. He approached the counselling service but could not engage in the counselling sessions in a meaningful way. He comes back periodically but such a student probably needs other support.

Counsellor OXB 002 147-150

It could be confusing for students to access different sources of help all at the same time. It gives students the chance to act up e.g. behaving well or badly towards different sources of support, not staying with their personal work but flitting between approaches and thus not moving on. This can also happen within the university e.g. tutors, hall managers etc may all be independently drawn in.

Counsellor OXB 002 160-164

Sometimes personal tutors will say to their students that they can deal with only some of their issues and they should seek counseling for those other problems.

Students often use friends for support, and friends sometimes suggest that they see a counsellor.

Other sources of support have included: GPs, the Health Visitor, parents and other family, the Barnes unit or a CPN. A student coming in from another area where they have had support, may have been advised to approach the counselling service for support here.

Counsellor OXB 003 39-46

Some have had counselling before and feel that they would like to use it again. It is remarkable how people manage problems and hold together for long periods of time before getting external support.

Within the academic process there are times when what is happening or being carried becomes unbearable, usually when the student experiences loss as a result of joining university and leaving family and friends behind, or when approaching the end, leaving what has become safe and known. However, these beginnings and endings 'triggers' are not in the student's consciousness, e.g. a student whose relationship ends and whose course is ending may experience great distress related to earlier anxiety around previous loss in their family. At the time they feel confused and helpless.

Counsellor OXB 003 47-56

Clients may have seen their doctor.

I had one case of a student being brought in by a friend who had had enough.

Some have not had counselling before but have seen posters which explain what issues they may come about.

Tutors may suggest referral. Because the site is small and self-contained, staff notice when students have problems.

Some students have had lots of previous therapy but what I offer is likely to be different. I assess what they want from me, and aim not to replicate what they have had before. Some just want to talk; they have their own problem-solving techniques and just want an appropriate listener.

I am interested in what is the student's vision of counselling that makes it worthwhile coming to me?

Counsellor OXB 004 73-84

Some may have a decision to make. Friends or family are pushing them one way or another and they want a more neutral space in which to reach their own conclusions.

Or it may be that they have had a previous good experience of counselling in the past and would like to prevent themselves getting worse. It worked before so it may work again.

Counsellor OXB 004 98-102

It is interesting to look at what their support network is. Out of the eight students seen: four self-referred, one was referred by girlfriend, one by family member, one by GP and one by a friend.

It tends to be a matter of coming when at the 'end of their tether' in many cases, certainly true of the two student mentioned earlier (one with bulimia and the other depressed).

When functioning on courses starts to be affected they may recognise the need to come for counselling. A couple have said work is going well, others really struggle getting into a downward spiral of feeling bad and work suffering.

I see the role as one of breaking the vicious circle. I don't think that students see any stigma in seeking counselling, this is shown by the fact that they have friends who say 'go'. It is more a sense of relief that there is someone who is not judging them and will be there for them.

Counsellor OXB 005 33-45

Quite often [counselling] is a last resort. Typical presentation is 'I can't go on, I'm desperate after having tried to get support from tutor and trying friends and family'. The student feels that something needs to happen.

There is a separate section of 'trained counselees' who use counselling well and recognize its value. I get quite a few of these and counselling may be their first resort. These are people who are using it well and effectively. Maybe more mature students are like this than the younger ones.

Counsellor OXB 007 37-43

You get one or two guys who, I suspect, want a male counsellor, but I am not aware of having young women students who have made that choice.

I have a protocol on students who come with academic issues e.g. not getting work in on time not structuring and it then becomes apparent that they need a counselling intervention. I makes a point of saying that you could work with me or you could work with another counsellor of the opposite sex on this. Some would prefer this after reflection, but most would not find this an issue.

Some women may want a male counsellor perhaps because of a poor relationship with their mother, and a good experience with a male teacher or their father etc.

Counsellor OXB 007 67-75

Oxford College of Further Education

Some students are offended and say 'no I don't want to talk to a counsellor'.

I encouraged one to see a psychiatrist although they were reluctant 'am I mad?'.

OFE 002 151-152

Oxford City Primary Care Trust

Some students say 'my tutor sent me' but usually this is not true. It is more likely that the tutor is concerned but the student is using this as an excuse to approach the Doctor i.e. 'this is not down to me, I am doing it to please my tutor'.

NHS 002 71-74

I would imagine that 50% have not tried anything else. Some have tried St John's Wort. Quite a few have been to a counsellor, some to welfare officers. Some are sent by parents.

A fair few have a long history and have been seen in adolescent psychiatric units before coming to university.

An estimated half have not previously had any contact with services.

NHS 002 97-103

For students away from home, their primary sources of help are not available e.g. family and friends. As a result, GPs see a lot of freshers.

Many do try friends and staff first.

Freshers tend to consult more but there is a large cohort of students who never consult.

Some students come forward saying, 'I have had these problems for 6 years and my friends say that I must come'.

International students may somatise the problem e.g. of depression, though this is in danger of being a generalisation.

NHS 004 70-77

The most recent was told to come. You don't know if what they have come in with is what the real problem is. I think as it is a close community there are a lot of people saying 'I think you should see the doctor'. Everyone has a fear of revealing a mental health condition. However, in this group they have less to lose than those on courses leading to high-flying careers.

NHS 018 153-157

Oxfordshire Mental Healthcare Trust

[What else has the client tried before reaching this stage?]

I don't know the answer to this. Some clients present early and some have sat on their problems for a while.

NHS 003 39-41

[What might be the reasons for these other avenues of support/treatment/self-help not meeting the clients' needs?]

This is difficult to answer. The longevity of the problem.

Psychiatrist NHS 001 64-65

Research in communities shows that people with OCD take 7 years to present themselves for help and this group is probably no different.

NHS 003 45-46

Quite a lot come for help because of the impact on their academic work, they can't sleep or concentrate or are so anxious that they can't get to tutorials, and tutors will sometime suggest counselling.

Other students are proactive, perhaps the problem has been going on for some time and they want to do something about it now.

The 'why now?' question is often worth asking when they first come. It can be a matter of chance. Perhaps they saw the number of the counselling service on a poster or a friend came and found it useful. But often it is impact on their life that is the precipitating factor.

Clinical Psychologist NHS 020 38-46

It is 50/50 as half had experienced support before, quite a few have had health service contact, quite a few have had previous counselling. It is amazing how quite a lot haven't done anything about their problem previously.

Clinical Psychologist NHS 020 30-32

Schizophrenia is very rare. Additionally, I rarely see psychotic illness owing to drug use unlike in mainstream psychiatric practice where this is more often seen. Students with such problems probably never approach the counselling service in the first place.

Psychiatrist NHS 019 154-157

What else has the client tried before reaching this stage? (*Services, strategies*)

Medication. St John's Wort. Counselling.

Psychiatrist NHS 001 57-59

They may well be known to social services, their GP or school counsellors.

Psychiatrist NHS 013 43

They are the more severely ill or have problems that require assessments.

Psychiatrist NHS 013 46

I do wonder sometimes, with the isolation experienced, if students that are withdrawn and withdrawing - if they retreat to where they feel safe – and it might have been picked up earlier if they had been with their families.

Psychiatric Nurse NHS 015 39-41

[Do you feel that most student clients referred to you are appropriate for what you can offer.]

I think so, not that we have many students. We recently had one Brookes student who was poorly. Unless picked up early it is often a crisis that alerts people to the person's problem. We had a student who was chaotic and disorganised, didn't know what was going on, there seemed no other way to manage this situation.

Very ill students probably won't access counselling if they are feeling they are going mad. If they have got to the point of being severely ill they need to come here. There must be those who don't access this treatment who need to, those who are shut away in their rooms.

Psychiatric Nurse NHS 015 76-87

I have noticed that a couple of student nurses have talked about house-mates with mental health problems and how they feel in a hard position with them. One didn't know what to do, in the end she wrote a letter to the consultant herself. In this job you feel you should help those outside you, e.g. friends, and you don't necessarily point them in the right direction to get help from services.

Psychiatric Nurse NHS 015 88-92

In the most recent case, the student was linked in with student services as their behaviour was bizarre. They were not accessing student services direct, but had been noticed because of what they were doing, and it presumably got reported. Most of the illest ones are like that, but others have been to their GP and have go to a point where they need to come in. Or they may have lost contact with reality, e.g. one was convinced he was being followed, that there was a conspiracy, he was very paranoid. But we know it was the reality for him. I tried some CBT with him, talking about his experiences.

NHS 015 96-103

A big part is support. I wonder if it is the stress and vulnerability, the whole new life which triggers some propensity to do with their family background. It also depends on how far down the line they are, and if they seek help early enough. If the person is confident or articulate they may access help earlier.

Psychiatric Nurse NHS 015 108-111

They have often seen a counsellor in a GP practice, or student counsellor, or they have tried medication, or St Johns Wort, or antidepressants and other medication.

Many are referred by CMHTs or alcohol services so they have used these services or had CBT before.

And there are people who have had therapy before who need a top up, or who have new things stirring problems for them.

Psychotherapist NHS 017 102-107

There are issues of race and class coming in. There are questioning issues to think about with certain students. That they are the first to come to university in their families. Those issues around change of role and change of class. There are also people from ethnic minorities with issues about whether you should talk about certain things. A western African student who I saw in my previous work experienced opposition to getting counselling. The pressure against her was enormous so she came guilt-ridden.

There is a sense of disloyalty in talking about family experiences and most people feel that about their family. They often feel very disloyal and I actively work with it. I say it is not about being critical, as parents do their best and there are things that got in their way. But our concern is its impact and to explore it, and so we can improve people's understanding. Most people find it reassuring if I say 'you might have felt that you were not well treated and that the point is not to criticise but to validate and explore your experiences'.

Psychotherapist NHS 017 141-157

The tolerance of problems is reducing, perhaps rightly so. Someone with a background of abuse in past would have had nowhere to talk about these things. There is more openness and more information and that is good.

Clinical Psychologist NHS 021 264-266

Psychological treatment is not always seen as the last resort, it may be preferred to services that are based in the student's university. Some have already used their university counselling service or primary care counselling. Some may have had therapy at home prior to becoming a student.

One student had been in a lot of therapy back home and was making comparisons. I can think of a few who have had a delay in getting the treatment they wanted and that is an issue for them as they are not used to waiting. Some will seek private therapy but there is not enough around.

Some leave home and seek help from the GP after leaving realising that they have problems.

Clinical Psychologist NHS 024 98-106

A CBT specialist, based in the Oxford University Counselling Service last year, offered earlier and easier access to treatment for those who could get over the hurdle of it being a university service.

In terms of desperate need there will be some who are not accessing psychological treatment.

Clinical Psychologist NHS 024 109-112

They may have tried university counselling services. As already mentioned, they would normally come through GPs and CMHTs first.

We do pick up people in their 2nd or 3rd year of study. It is amazing that they have got that far without being treated, and this probably reflects the higher level of tolerance in colleges.

Clinical Psychologist NHS 025 106-110

We have had people who have had a year or two out, especially those in their 2nd year. That can be a good decision e.g. one student who took a year out and went back and got a First.

Clinical Psychologist NHS 025 110-112

It is a private thing, especially bulimia or binge eating and purging generally. Anorexic people don't want to talk about it, or they don't recognise that they have a problem.

Clinical Psychologist NHS 025 136-137

Appendix 4

4.1 Oxford Brookes University

4.1.1 Students providing support at Oxford Brookes University

[How is the student assessed as being suitable for support by the student supporter?] It is a fine line. I will concern myself with academic and resource issues, assignments. I sometimes talk to friends who need to say how bad things are going, depends on the course rep or friend's role. As a rep I will hand on to other sources of support. I don't have a problem with suggesting contact with a counsellor or with friends outside of the situation.

Student OXB 001 50-55

I had a fellow student phoning 3 to 4 times a week for an hour each time. This went on for over 6 months (previously the friend would have phoned maybe twice a week for similar length of time regarding some matters that were a problem for her).

Student OXB S02 20-23

In the instance given, the other student was dragging me down too much and I was avoiding college so as not to see her. In future, earlier on in the other person's ongoing need for answers, I would try to ensure that they get someone else to help them find their own answers. A line must be drawn. I helped the person access other support out of his/her own frustration. Making the first step is hard e.g. getting into counselling or even recognising you have a need for support.

Student OXB S02 48-53

[How does the student help other students?] It is listening and giving some feedback, showing empathy, reassurance offering options. With the demanding student I saw that her problems had become fixed and were not moving, she had a lot to deal with.

Student OXB S02 72-76

In the 1st year I felt that a fellow student should see someone about their problems, and I referred to the existence of the counsellor in a coded way and encouraged the student to go.

Another student that I met on placement had come back from a year out. I supported her at the level of friendship perhaps as a 'parent figure' to her. We helped each other academically.

Student OXB S02 54-59

None of my good student friends had serious problems, but there were others who knew my history and approached me because they had friends with problems and perhaps it was bringing them down and their peer group down. I helped them to feel that they could be able to give reassurance and to try and share responsibility a bit, rather than take it all on themselves. Just having someone who had experienced something similar and knew what it was could help.

Student OXB S03 12-17

Students probably don't know enough, but I am not sure if students who haven't experienced mental health problems or don't have a friend with experience of such problems would be interested?

Student OXB S03 87-89

By personally being open you are able to help someone privately deal with their feeling and emotions without them having to discuss their own personal feelings.

It can be an opportunity for people to acknowledge and accept their problems in a safe and secure environment.

Student OXB S03 184-188

4.1.2 Tutorial support at Oxford Brookes University

People seem to find it hard to get hold of their personal tutor or the right person to ask about something. This lack of contact causes much concern and reinforces the feeling of isolation or a sense of not belonging. However, some have a great relationship with a tutor, so there is a patchy picture, it is partly a matter of luck.

Counsellor OXB 008 197-201

If I look at my colleagues I would suggest that most are pretty supportive. I likened it to a family and they ask each other to keep an eye open for particular students. There tends to be those who bear the majority of the caring roles, the 'good' tutors. There are others who can't stand the hassles.

Tutor OXB 020 156-159

Perhaps there is a need for the student to find their tutor and talk to them. Timely access is a problem. A lot of things are probably dealt with by tutors but there is inconsistency between those who dislike anything psychological and those who are very capable.

Counsellor OXB 009 186-189

Tutors are generally quite supportive and interested in what students have to say on academic issues, though it is difficult to get that across to students.

Student Representative OXB S01 85-86

I fear I have got a reputation of being a difficult student. I have been very direct but not rude to staff. I have had three tutors in a row who are not good at their teaching. Some are not even qualified in the professional subject area. There was the case of the teacher teaching research who had never done any research themselves. Another example is a psychology lecture where 7 approaches were covered in one hour!

Student OXB S06 51-55

The majority I would refer on. I am supporting one student whose father died suddenly. I supported her basically. Every one I have seen I have shifted on to counselling or a GP.

One member of staff took me to task for seeing so many students. But I pass them on to counselling or GPs. I rarely see them more than once or twice, once they have found some external support.

Tutor OXB 021 99-103

Not everyone is good at personal tutoring. Some don't have the time or the skills and you hear of some students who want to transfer to me because of that. The danger is that you can end up with a long list of people. The Department once tried letting students go to the more involved tutors and I had 60 tutees in one year, but it didn't work.

Tutor OXB 020 64-67

I notice that students will follow up the subjects that we have just covered with related concerns, some of it will be about family members. Inevitably there will be students who have parents or siblings who have died by suicide, or who have has a major mental disorder, e.g. bi polar affective disorder, or they will say 'I am depressed'.

It is the degree of stress they are under. One young lad turned up to an exam and said 'I just can't cope, I'm not coping with life.' My immediate reaction was to send him to counselling. We got him an appointment and it worked out. At that time I was in an exam and couldn't do anything else for him. At another time I might have offered more direct support.

Another indication is if it is ongoing and longer-term, then you can offer them the counselling service. But we do that with a certain amount of reluctance as the counsellors are busy and they have said don't send all your students to us.

Tutor OXB 020 17-23

If it was an ordinary life event, I would support them there and then. But if it was extreme, then I would refer them on. Those who have had relations commit suicide I would refer on. I would make that as a clinical judgement. I am there for pastoral support but this (suicide) needs more sustained work than I could offer.

I would offer support to those with significant traumatic life events and will take more time. If they need more support I will suggest counselling. I would sit and talk with them but will suggest referral.

If they are coming and feeling flat and down, I will ask clinical questions e.g. about sleeping patterns. If necessary I ask them to go to the GP, I would say that you have the signs and symptoms of depression and that medication that will take the edge off it and then you could talk to someone (counselling). They do go and feel better after getting medication. And they go to counselling and I won't hear from them again. The only two who were not open to this, were the two with schizophrenia.

Tutor OXB 021 77-89

There is the occasional person where you are afraid that they might take their own life. I had one on a Friday afternoon and rang Student Services and there was nobody that could see her. I had to suggest to her that she got in touch with her parents or the Samaritans. She had a history of self-harm and I thought she might self-harm, she was beyond approaching the GP. It worked out but perhaps I should contact X [Head of Student Services] about the issue of access during a crisis.

Tutor OXB 022 103-107

I try to find out the root cause. Is it a situation or it a medical condition? Some have medical depression, they lack the necessary vitamin or whatever, but some have depression caused by a situation. I try to find out by chatting. If medical advice is needed they should be chatting to a doctor, so I ask if they have ups and downs in the family. I don't mind telling them that I cope by taking the right pills.

If it is situational then there is the tea and coffee and tissues, and as weeks go by it is something they can come to terms with.

Tutor OXB 020 103-109

4.1.3 Residential staff support at Oxford Brookes University

Normally incidents are picked up by wardens in the evening e.g. The fire alarm going off and the same person always being around at that time. Or the person being abusive to wardens, they may argue with you every time you speak to them. With some students in their residences during the day time, you sense that things are not right...

A student's mental health problems are occasionally brought to staff's attention by a flat mate, but less so in the large residential block than in the hall where they are grouped together in flats. In that setting there are more complaints.

Hall of Residence Staff Member OXB 012 21-28

In the hall there are 250 students so you know faces but not people, and it is the flat mates that will raise the concerns.

Hall of Residence Staff Member OXB 013 5-7

You could say that wardens are more likely to pick up problems than the hall managers who work office hours. Often problems emerge when students come back from their day when they are isolated and lonely in their rooms.

Sometime difficulties have been communicated to the hall manager and hall wardens have been asked to keep an eye on these students.

Hall of Residence Staff Member OXB 014 9-13

I can think of three or four students who need that extra attention to know that they are not on their own. They need someone to talk to. Wardens officially don't have a pastoral role, they are more there for safety and security reasons, but a lot of students are worried about being away from home and need support.

Hall of Residence Staff Member OXB 011 37-41

With the anxious students, I try to find the line between having them moving in with you and tipping them over the edge, I try to give them enough attention to reassure them.

Hall of Residence Staff Member OXB 011 66-68

Wardens are not trained counsellors or mental health workers. The warden is the first point of contact and they know where to send people. They are not expected to be experts but will do what they can, but will call out the professionals when necessary. The warden's handbook advises you on how to approach a situation and where to get help.

I will try to ascertain how they are, what can be done, and ask if they have any idea why they are in the situation. I will ask if there is anything I can do to help them feel safe. I will also talk to the other students and make sure that they are OK and are not going to exacerbate the situation.

Hall of Residence Staff Member OXB 013 49-57

[I would appreciate] the value of a training course on different types of mental health problems and why people behave in the way they do. Training people to deal with it. It is particularly frightening for females to deal with large male students.

Hall of Residence Staff Member OXB 012 120-122

The counsellors haven't got the resources, and they are more careful not to get sucked in to activities beyond their hours. However, Hall Managers are sucked in because of the fear of suicide, and they do a lot of onsite counselling. I am wary of doing work on my own with people, I wouldn't do work with a disturbed student on my own. There are times when you are on site on your own and so are quite vulnerable.

Hall of Residence Staff Member OXB 010 93-98

You go in blind. In a few instances you don't now how to deal with the situation, for instance, is there a history of violence with this person? Yes there must be confidentiality but hall wardens are out there on their own and are expected to deal with disturbed students when counselling is shut. They need a system to allow insight into particular cases as it gets quite worrying when you are uninformed. It is a matter of finding a balance. If it is the four wardens that are dealing with the problem it would be fair to forewarn them.

Hall of Residence Staff Member OXB 011 49-55

When dealing with mental health issues, it is usually left to one member of staff to deal with the individual, the situation they have presented, and the other people that affects, including themselves. The back up just isn't there. Someone on the end of a phone is not always substantial enough to deal with the situation.

Hall of Residence Staff Member OXB 010 104-107

I asked if they could tell me if the student was still receiving counselling, but they couldn't even say if he was being seen. I feel that it should be a two-way flow of information. Residential staff only want to help, but because of the Data Protection Act and codes of confidentiality, they are held back. If the counsellor could have given advice to me and discussed the case we could have worked out a way forward together and supported the student.

This is the frustration with Student Services, residential staff pass their concerns on, but the counsellors etc. say 'we can't tell you anything back'. But I say we can keep that information confidential and they could include us, it would be better for all if it was shared.

Hall of Residence Staff Member OXB 012 68-77

There are so many issues with confidentiality. I know it wouldn't be fair for Counselling to reveal everything about a student, as it might prejudice others against them, but other people could be in danger so they need information. Wardens are respectful of confidentiality and wouldn't abuse information given to them. You don't get much information, so you don't know the other causes and effects on the student, and you don't know whether you need to know or not. The problem may go some way back but you need to know something about their behaviour before and what can be done now.

Hall of Residence Staff Member OXB 011 83-90

There has been a loss of links between Student Services and wardens. Previously it was run by Student Services, so there was an ethos of providing help. Now there is a feeling that the halls are hotels, the student supporters don't fit in and the staff are there as landlords rather than supporters.

Hall of Residence Staff Member OXB 017 14-17

The wardens' role is advertised as a disciplinary one and this is a break for those who didn't want to make it a 24 hour post. It must be remembered that the students' 1st year is crucial and there are ways that it could be improved but it will involve some work. The personal care aspect is going to have to return if the university is to become more than a degree factory.

Hall of Residence Staff Member OXB 017 25-29

4.1.4 Counselling at Oxford Brookes University

The counselling service provides what the student needs in order to complete their studies, it is not intended to provide ongoing therapy (the service normally offers six sessions). In exceptional circumstances more sessions may be offered dependent on a student's need. If I suspect borderline symptoms of mental illness, I will arrange for the student to see a consultant psychologist attached to the service. This is a new arrangement aimed to meet the needs of the slow but steady increase in the numbers of students with borderline problems. With the external constraints e.g. the length of the NHS waiting lists, the reassurance of a fast internal response contains staff and student anxieties. However, there is a danger that the rest of the university views the counselling service as the place to refer the difficult students.

Counsellor OXB 002 30-45

There are resource issues which need reviewing, the limited resources mean that the counsellors can't deal with long term therapeutic issues.

Counsellor OXB 003 15-17

There is much personal developmental work going on whilst at university, even for mature students, and so it could be effective to do work in depth during this period. Longer term therapy is available privately but is too expensive for most students. It is sad that the service can't do more long term work, but I know that it is a resource issue. Through knowledge of psychodynamic work I know that 10-20 % of clients could benefit from longer work, so this is very frustrating. The term time pattern also influences the length of work. Students too find it frustrating as they are aware that they could do more.

Counsellor OXB 006 210-217

I would suggest that they see a GP e.g. if they had severe depression and might need anti-depressants. It is not often that I can't work with someone, but sometimes the client needs a shared support route with additional input from another service.

Counsellor OXB 003 167-170

There are some referrals that are inappropriate for example from academic colleagues who refer students with severe mental health problems to the counselling service. This is worrying for the counsellors and worrying for others. Such students then need to be referred on from the counselling service via the GP. Such inappropriate referrals are confusing and time wasting for the student.

Counsellor OXB 009 175-179

I see some cases of severe depression and occasionally psychotic students. I am more able to work with those students with severe depression but I do suggest to them that they also seek medical advice. I am not against anti-depressants unlike counsellors some years ago. Counsellors must be careful of the need to get a second opinion in the case of those who are severely depressed due to the risk of suicide. It is not so much a matter of being defensive but of seeking the best care for the student.

Counsellor OXB 009 19-23

Given the pace of university life, extended therapy is not appropriate to the age and lifestyle of students. The service can achieve outcomes with brief therapy. I was involved in the transfer to the brief therapy model in my previous university post. In this model there is solution-focused work with students which can address important things happening right now.

OXB 004 67-70

I have been trained in the integrative approach to counselling which combines person centred skills and psychodynamic perspectives and understanding, and operates in a transpersonal context. This approach was developed for longer term work and I am learning to do this in a shorter time-frame.

Counsellor OXB 002 90-92

I have adopted a psychodynamic model, working with defensive issues and transference. It is hard to know if it works for all. The main element is relationship based ... Positive regard and empathy, all those factors enable the client to find what they want to say.

Counsellor OXB 003 95-99

Once off the psychodynamic training course I will work within an integrative approach, as that way seems best, especially in short term counselling work. Those who work psychodynamically see a danger in cognitive work, in that it will cause the problem to pop up elsewhere in the person's life, due to not dealing with deeper causes. Cognitive Analytic Theory possibly picks up on both approaches and might be worth looking at for the future. I wonder about the value of a pure cognitive approach but a psychodynamic approach can take a long time, and that is an issue in this context.

Counsellor OXB 005 61-85

I take a psychodynamic model combined with sympathy for a humanistic approach. I have occasionally worked (with three people) explicitly in a cognitive mode. This decision was reached from a trial interpretation that the clients could not use a psychodynamic approach. In two of the cases their

emotional language was so lacking that it would take long-term work to engage them in the psychodynamic process effectively. It is more the nature of the student than the problem which determines the approach taken, but occasionally a circumscribed problem e.g. with studying, might indicate which approach is most likely to be effective.

Counsellor OXB 006 53-60

Short therapy can do a lot of work on bereavement. It can be brief and psychodynamic.

For separation issues the psychodynamic approach is the treatment of choice, students may use me as a transitional figure to help with separation from their family.

Counsellor OXB 007 225-227

My background is psychodynamic but student clients may not notice the difference this makes in my work compared to that of other counsellors. Even if not working in an explicitly psychodynamic way with the student, I will be thinking about earlier relationships and transference and would take a full case history and look for links with past experiences. The student will often be looking for this link themselves. However, if someone wanted advice on how to deal with e.g. panic attacks, I would respect this but would still ask what the context is.

Counsellor OXB 008 115-121

I started by using the humanistic style. However, that didn't seem sufficient so in 1980-82 I undertook a part-time psychodynamic course. In those days I worked much more psychodynamically than is the case now. However, now I am probably not so good on the psychodynamic side, as I am not offering long term therapy and self contemplation. I now work more integratively. It is short-focused therapy. Most student clients want to improve yesterday in order to continue with their studies so they need a quick therapy. I get a feeling of what methods are appropriate to the client. I may be in tune with some clients and work with them on the unconscious elements and can work analytically. Others would rather not. Therefore I use a mixed bag of tools.

Counsellor OXB 009 89-99

4.1.5 Views on the quality of support at Oxford Brookes University

At this university it is anonymous. It is OK to not invade students' privacy, but staff should take up a prolonged absence by getting in touch. Students would call me but not the teachers.

Student OXB S06 164-165

The modular course structure is very atomised and the way it works goes against peer support, creating a fragmented student experience. Student health can be enhanced by improving access to personal tutors but this access is additional to their work. Much else is required of academics, so the issue is partly a resource one. It is important to address the structural side of mental health in the institution.

Counsellor OXB 002 195-199

Students are thrust on to a modular course, finding they are a number not a name, this promotes anxiety. It is difficult for them to see their tutor, academics are under pressure for RAE and quality assessment exercises.

Counsellor OXB 003 140-142

For some tutors it was a long time since they were a student and they may not be aware of the different (increased) pressure on students now. It would be good to have an awareness raising exercise available to staff on the current situation.

Student OXB S01 139-141

The problem with Counselling, or attendance on one of the Health Visitor's groups, is that once you have persuaded the student to go there is a waiting time of a few weeks. They probably lose quite a few clients because of this.

Hall of Residence Staff Member OXB 010 85-87

The situation is much more complex than merely obtaining permission to share information. You need to ask: 'are we all speaking the same language?' and 'what are the likely repercussions of revealing these problems?'. This leads to the need for wide training for staff on what mental illness really is, what impact it can have, and what their responsibilities are under the Data Protection and Human Rights Acts.

Counsellor OXB 004 250-253

There is always the Head of Student Services at the end of the phone if I need advice, he is good, 'the voice of calm'.

Hall of Residence Staff Member OXB 010 130-131

We have had very good communication with X [Head of Student Services] at Brookes and that was very helpful. Clinicians communicate about their patients with me and not many raise student issues. Probably the biggest is if the student is having problems in their house and X has been brought in to help with that. A lot are probably contained by the university's counselling service.

Mental Health Service Manager NHS 027 12-15

4.2 University of Oxford

4.2.1 Students providing support at the University of Oxford

Support falls too much on a few people. The people that are sought out are often the high achievers. Perhaps because of their personality they are well known so get approached.

Student Representative OXU S04 235-237

I think that students with problems rely on their friends for support too much and can overwhelm them. There is a need for a link to official routes of support to address students' reluctance to use the counselling service or come to a support group. The problem is that people like to be informal and impromptu and as a result everything comes out at 10.00 at night with the student in tears. Rather than seeing a need to approach support, the students see themselves as needing a cup of tea with a friend.

Student Representative OXU S04 223-228

Often they are aware they are off-loading too much on to friends and are becoming a burden. Or they want to keep their emotional problems completely separate from their friendships and want to project an image that they are coping.

Counsellor OXU 012 62-65

4.2.2 Peer Support at the University of Oxford

The peer supporters are about de-stigmatising the [Counselling] Service and will reassure the student that they are not being burdening or that their problem is not bad enough. Peer supporters have to believe that themselves, if not they may try to take on the problem themselves. If someone comes back from the

Counselling Service saying 'it's no good' the peer supporter can unpack the issues around that. They might look at where the stigma of using counselling comes from and will explore that.

Counsellor OXU 013 36-42

There has been no research in colleges, but I can see changes in the colleges that have participated. One way to tell is when applications for training are received from students in a college that has had peer support for some years. Applicants may say that they have found peer support useful or have been aware of it and that it is good. I went into one college for Peer Support training, where students had said how poor the social atmosphere was, very macho and no welfare focus. Now nine years on it has a much more positive atmosphere.

Counsellor OXU 013 45-52

There is the peer support panel which is not used much formally, but the people trained through it do find it very useful as people do approach them anyway on an informal basis. Therefore, although there is scepticism that the panel don't get approached formally, the people who trained know the value of it and know that approaches don't need to be that formal.

Student Welfare Representative OXU S04 169-175

4.2.3 Welfare Officers at the University of Oxford

The vast majority of what I encounter is friendship and relationship problems. Having someone neutral to talk to, that is what is most important. It is like talking to a friend outside of the friendship situation. The role is sporadic, sometimes I will see two or three people in one week, other times it will be quiet. There is stress around exam times. As there are four welfare officers the work is evenly spread, but you are always aware of things going on.

Student Welfare Representative OXU S02 19-27

With the [clinically depressed] student mentioned, I asked how it went on a weekly basis and showed that I was still concerned. I didn't want him to think that he was being swept under the carpet. It was a matter of getting help outside of the College and then rejoining the College community.

Student Welfare Representative OXU S01 63-66

In most cases, students approach me for information or a reassuring chat if they are stressed. They also come forward if they don't want to use the counselling service. I will acknowledge that stress is serious and that the student should get further help.

Student Welfare Representative OXU S03 46-49

Peer support is a mixed blessing, it is allegedly trying to help them to say no, but the peer supporters get access to counsellors and as a result pick up their concepts and try to emulate them. The value of peer support training depends on the individual. It is probably a good thing since they are the ones who will be taking things on anyway.

General Practitioner NHS 002 86-90

JCR Welfare Officers need training and support. Some don't have an awareness of peer support and it is shocking to see what they are getting involved in. They can be arrogant in thinking that they can deal with things they can't. It is so claustrophobic that people are interconnected. If people engage out of good intentions but with ignorance and arrogance, that can cause a lot of damage if left unsupported.

Some of the officers are compulsive helpers while some do it for their CV. There is an example of a 19 year-old welfare officer who said in a meeting, 'It is only the severe eating disorders that I can't deal with!'. Welfare Officers really shouldn't be dealing with that level of distress in these serious areas. They need to be educated not to intervene but get professional support. They don't understand the confidentiality limits and can get trapped, burdened and manipulated by those students who say, 'only you can help me'. I have seen people in tears over this pressure and there are no established barriers.

Welfare Officers will end up talking to very disturbed students in the middle of the night and feel that they are the only ones available to support these students.

Counsellor OXU 003a 84-97

4.2.4 Tutorial support at the University of Oxford

There is possibly a lack of realisation by tutors that they need to help some students keep things in perspective by saying 'you look tired, you mustn't go overboard'. People's moods can change a lot, e.g. students can feel great when they are complimented by a tutor but criticism has the opposite effect on their moods. In these cases, friends support the student through and the college has talked about this at academic forums.

Student Representative OXU S04 152-157

In order to stay effective and study well you need to be a balanced individual. Staff may say 'if no exception was made for me when I was suffering why should I do this?'. Just because they suffered we should too' – this mentality prevails.

Student Welfare Representative OXU S06 297-299

Some tutors are good but there are some horror stories. You do hear a lot about unavailable tutors, supervisors who are aloof and distant. Often to have a Head of Department as your supervisor is bad news as they are not so available to the student. So reported problems are not just the product of negative thoughts, they can reflect the real situation.

Clinical Psychologist NHS 020 93-97

Some tutors have been very caring about students I have treated and we have been able to liaise in a helpful way e.g. in the case of a suicidal student who was very able but doubted herself, collaboration with tutors worked well. However, it depends on the personality of the students and tutors involved. In pastoral care the better the relationships the better the care.

Clinical Psychologist NHS 024 146-150

For some academics, study has been their whole life, they find it difficult to deal with the student who wants to develop their emotional and personal life.

Counsellor OXU 011 81-83

Sometimes tutors are a bit determined not to accept that their charges are mentally ill or might have a problem, perhaps because they are nearly all men, and are more academically focused.

College Staff Member OXU 018 174-179

The first thing is to tell the student that that tutors are not professional counsellors, and then straight away I would try and persuade them to seek help. I will listen to their problems and give advice. I tell the Junior Deans that if the student is depressed etc. you must pass it on and not be too responsible on your own. It is more important to be a friend and help them through and that they should get the college authorities to help them through.

Tutor OXU 019 52-57

If it is to do with things like the student struggling with work, I feel able to talk to them about that and to give advice and give them things to try out and for them to come back and see how it is going.

In the case of those students who present as rather low for no apparent reason, I will ask if they would like the number of the counselling Service. One student found it very helpful and she has had help from the exam stress specialist. However, not all want to see counsellors.

For students who I know are close to the chaplain or who participate in chapel activities, I might ask if they mind talking to the Chaplain or may ask the Chaplain to keep an eye on those he sees. I always tell students about the student welfare representatives, but they probably won't take this sort of problem to their peers.

Tutor OXU 020 30-38

If a student approaches me about issues such as not getting work in on time or not managing to write a piece of work, I would try to give them more time to talk. I would not try to provide counselling. If the problem is an academic one, I would refer them to the supervisor, if it is deeper, to the GP. I can get an instinct about what is going on and can say to the student that this is a common problem. I can then say to the student 'what you can do is...'. As long as you give the students time to talk.

Tutor OXU 023 46-51

4.2.5 Residential Staff at the University of Oxford

We have got one student working for the college library to get him out of himself and keep a watch on him and to integrate him e.g. by inviting to a meal with summer school staff, but we are careful with the seating plan putting him between the two of us.

Here we are lucky to have so many mature women who have had their own children but don't mother the students, but can advise and help them. Support is generally a private thing and you hope it is working for them. They latch on to one person e.g. girl latched onto a male student as her boyfriend, staff worry about the affect on the boyfriend especially as they will be living out next year together and staff wonder what will happen?

College Staff Members (2) OXU 018 153-162

[Suitable for support?] I will judge this by how the student reacts to chatting to me. If I don't feel that the student is getting any better, I will encourage them to go to the college Doctor or Counselling Service as I am not a qualified counsellor. It has to be a simple problem for me to address.

In some cases, the problem can have a simple solution, for example in the case of a lone XXXX [nationality] student, I e-mailed other college secretaries and found other XXXX [same nationality] students for him to meet with.

Often people just want to have a chat, they are good at looking after each other.

College Staff Member OXU 021 46-53

4.2.6 Counselling at the University of Oxford

In this age group there are many students who should be getting longer term support than is currently offered, but there is a lack of resources. Clients usually want to leave when they feel OK, the Service doesn't encourage dependency in the long-term, only what is appropriate in the short-term counselling relationship.

Counsellor OXU 003 29-32

I saw a male student for three years (it is unusual to do this but it was extreme). He saw a chaplain weekly but we didn't talk between chaplain and counsellor.

Counsellor OXU 007 165-167

Each week I carry out four assessments and then have to balance out the number of sessions offered. This may be over the long term or 3 or 4 weeks (long-term can be anything up to a year or beyond). However,

given that the counselling service is trying to work in 5 sessions, the service would view anything over 9 sessions as long term.

Counsellor OXU 008 66-70

If the cases are severe then they are picked up. Some are carried even though they are not appropriate as there is a feeling that they have to be dealt with as there is no other support available e.g. if a student is suicidal I can feel pressured and may offer more than four sessions.

Counsellor OXU 004 153-156

The difficult one is when someone arrives saying 'the GP says I should have cognitive therapy, but in the meantime I should see you'. They won't be seen for months at the Warneford and there is a sense that they are having counselling but are waiting for the 'real treatment'. So there is the need for the kind of waiting period, where they could have benefit from the counselling without feeling that it is a poor alternative.

If they do get access to the Warneford out-patient services, I won't undermine what they are doing there and am happy to hold them while they wait.

Counsellor OXU 005 128-134

I do not believe that you can work with a 'pot-pourri' approach i.e. mixing models. I believe that this is too risky and you must know what you are doing, unless you are working with the more healthy students where it might be possible to take a few risks.

There is a percentage of students who can't work using the dynamic approach e.g. because they are phobic or OCD or where a capacity for making links or getting insights is lacking.

Cognitive Behavioural Therapy would be offered to some and I have referred three on to this treatment this year. However, personally I am reluctant to use CBT as I am trained to work in a psychodynamic way and in group analysis. I would go along with the view that CBT only addresses symptoms whereas the psychodynamic approach can get to the heart of the problem.

Counsellor OXU 008 71-82

CBT will make a difference to self-esteem, especially female self-esteem. I am not so keen on the psychodynamic route for therapy. The Counselling Service could choose to employ a CBT specialist rather than just having all psycho-dynamic counsellors.

Mental Health Care Worker NHS 007 60-63

From my point of view the psychodynamic approach doesn't work but the head of the university counselling service is not supportive of a CBT approach. The counselling service has been persuaded to take on a CBT person but it has taken a year to get someone in post. It should not be that difficult to attract someone like that to work in a university setting.

Quite a few patients say, 'I have been to the counselling service and they were useless', which is unfair as they went expecting to be told what to do. In CBT at least they feel that the therapist told them what to think!

General Practitioner NHS 002 129-136

Having a counselling service is essential for the functioning of the university. However, it might be more effective if all the approaches were represented rather than one or two since some students do not respond well to psychodynamic/cognitive behavioural approaches. I know of students who have had very good and very bad experiences from the service, but it is an individual thing and very difficult to judge from the outside.

Student Welfare Representative OXU S06 216-220

I have worked with many clients with depression and have worked with them very psychodynamically or very cognitive behaviourally! It is the same for anxiety and panic disorders, if they seem ready to work in

metaphors, can take a psychodynamic approach, you can get those 'ahah! moments' of self-understanding in the client. However, some clients would be uncomfortable and suspicious of the psychodynamic approach... There are those student clients who don't want to look at the past, and so I would use the CBT model with them. But if they can respond to a dynamic approach I will use both models.

Counsellor OXU 005 68-77

The service works mainly within the psychodynamic model. If the problem needs a particular orientation e.g. sexual health problems, obsessive compulsive disorder or certain kinds of depression I might bring CBT in to my work.... The service already has specialists using a CBT model, these cover study skills and eating disorders.

Counsellor OXU 003 120-122

If I had a sense of unreality and felt strange and weird in the work with a student, I would want to work with the psychiatric consultant on the case.... I feel I wouldn't have the confidence to work with this group without consultation, the intensity of changes at this age can verge on a psychotic quality.

Counsellor OXU 005 158-166

The Counselling Service has always had a consultant psychiatrist attached to the service and this person can liaise with the mental health team.... The counselling service staff can write the consultant psychiatrist a letter asking them to see a student and they'll see the student in the same week. The consultant psychiatrist will look at the counsellor's opinions and usually will agree.

Counsellor OXU 007 185-189

The message gets out that the counselling service is busy, students have to wait, the service doesn't have time for you and that the service is under-funded. It is a shame given the status of this university that it can't afford a few more counsellors.

Student OXU S03 153-155

It is said that people do complain about the waiting times, the wait for the Counselling Service - the service is under resourced....

I am prepared to hear a case for more resources being allocated to the Counselling Service and am sympathetic to this as a two week wait is a quarter of a term.

College Staff Member 022 97-98, 115-116

A problem with the Counselling Service is that having just persuaded a student to see a counsellor, they are then told 'you must wait two weeks'. It would be nice to get the appointment ASAP.

Tutor OXU 019 103-104

They [the College] were suspicious of the Counselling Service which was seen as part of the university and they wanted something on site and confidential. In this setting you tend to get people who wouldn't go to the Counselling Service yet, but would wait until things got worse, so it picks up problems at an earlier stage and that can prevent a worsening situation.

Counsellor OXU 005 228-234

For a time there was college counsellor... the students were very embarrassed about going to the designated room at the designated time. The feeling was that they would have written all over them 'I've got a problem' and they preferred the centralised, more anonymous service. Also there was no choice of counsellor. So it wasn't continued.

College Staff Member OXU 018 127-131

I know that students have gone to the Counselling Service. Some have been helped and some haven't connected with what is offered

Chaplain OXU 017 118-119

Some students have gone for counselling but have not been happy with it and as a result it is then difficult to convince them that they can be helped. How can I reassure them that it won't happen again?

Student Welfare Representative OXU S06 61-62

I can see the benefits of counselling and will say to others 'you are lucky to have the time to get that attention'. Fellow students who are so busy have limited time and energy and cannot offer such support. I think the Counselling Service should be used more, but also believe that people will go when they are ready. Everyone probably knows someone who does go and I wish that more would suggest it as an option.

Student Representative OXU S04 194-200

4.2.7 Medical support within the university/colleges

Having someone like the nurse with the right training can provide a halfway house or she can pass on to the right agency. Psychiatric training should be required for College Nurses.

College Staff Member OXU 018 139-142

The Nurse can go to a student's room e.g. if they are depressed. I have intervened many times when the student's behaviour is bizarre, the role is more like that of a CPN. I will get involved and can be more proactive.

College Nurse OXU 010 126-128

I think the college nurse deals mainly with medical issues. The person has changed and I am not aware of her having any mental health knowledge. I am not sure that a student with mental health issues would go straight to her but doesn't know this for certain since people do know of her which is an advantage.

Student Welfare Representative OXU S03 65-66

College Nurses can be good but can get out of depth with students in extreme distress. One nurse panics and calls for help as soon as he/she gets a mental health case.

I may look for students' friends for support but this is not always ideal or good for the friend.

Counsellor OXU 004 141-143

I am RMN [mental health nurse] trained and don't know how other college nurses cope without that background. I instinctively pick up on body language and how they talk.

College Nurse OXU 010 10-12

[How is the student assessed as being suitable for the nurse's input?] Very much a rule of thumb. It depends on the severity. If their mental health is affecting their life e.g. not able to eat, work or sleep, I will refer to the GP to see if they think it needs drug therapy. I tell everyone about the counselling service. If there is any threat of self harm or eating disorder I send them to the College Doctor to get a baseline. They often come to the Nurse because they are not sleeping, or are talking about taking paracetamol etc. in the latter case I would pass them on.

College Nurse OXU 010 3-10

We would not necessarily be involved if a student develops a mental problem, as it depends on the college or department as to where they are referred. Occupational Health are referred graduate students from their department (but not from their college). The managers are treating them like staff, so they will get a similar approach as any other management referral of a member of staff.

A classic cause for referral is when staff have noticed that a person is not turning up for work, are sounding depressed and are obviously not well, and the department want advice. In this case the project is often not going well and there is a danger that the student may not complete.

Occupational Health Physician OXU 014 11-19

4.2.8 Views on the quality of support at the University of Oxford

Others cling on due to the protective nature of college, in a sense we let them down as it is not the real world and the experience may infantilise the undergraduates. Sometimes you should say 'x must do some growing up', they have to face the big 'no' sometime in their life rather than always being given into.

I do think it could be different. There is a fine line between providing a safety net and creating the cocoon which should not be there, staff should not be in a paternal role.

You may feel the need of those who help that they tend to over-help, e.g. to spend all night talking to a student and to have infantilised them. I have seen staff who have had very fuzzy boundary.

College Staff Member OXU 015 33-40

The College's Pastoral Committee meets 2 times each term in week 2 and week 7 to see what problems arise. College B has a pastoral lunch where staff can share concerns but things said can get back to students via staff. They get concerned about some students and not others. I do not feel it is safe to raise things there as there has been a student perception of the leaking of personal secrets.

College Nurse OXU 010 135-138

The bursar and myself both think that only *issues* should be raised not named students. At College A, the previous president was very huffy when I said that I couldn't discuss students. He thought it was nonsense since everybody on the committee was concerned for the student's welfare. I had to hold my ground but it was uncomfortable. When the new president was appointed I wrote to him saying 'please don't put me under pressure to reveal students' details in these meetings. Unlike the lecturers I could lose my chance of having a job in the profession if I breached confidentiality'.

College Nurse OXU 010b 69-76

It is a large committee and is useful to know someone has been bereaved etc.

The President attends, it is convened by the Dean who knows most undergraduates, the College Nurse and Doctor don't say much, there are lots of junior deans, tutors for undergraduate students, the chaplain, tutors for graduates and the accommodation manager who is very aware of who is doing what, who is sleeping with who, it can be that you know more than you want to some times. I am in favour of privacy for students.

The Dean goes round the table and staff will mention any concerns. I rarely mention people as I don't operate that way.

College Staff Member OXU 015 5-14

There has been a warning from past welfare officers that you can't trust the confidentiality of welfare meetings, and perhaps a worry that information shared might be used against people. So there is a slight level of distrust and anything that could be done to improve this would be good.

Student Welfare Representative OXU S02 117-120

4.3 Oxford College of Further Education

It is when the student is psychotic that staff have to get involved with other agencies. It is not straight forward as there is not always medical help available.

Tutor OFE 002 25-26

Some GPs are appalling and it is difficult to say go to your GP.

Tutor OFE 002 159

Usually you are talking about agreements to make some resources available, where these are wanted people make a referral and it often isn't seen as serious enough by external professionals. Conversely multi-professional work is about understanding the roles of others, they can get professionals diving in with lots of expectations of what you should be doing, and from staff's point of view it doesn't seem to be manageable.

Tutor OFE 001 117-121

The staff find it difficult to get hold of information from agencies which they need. Staff see the students more than the agencies do, and it would help to have information about the student's background, such as have they had MH problems before? The trainee may not tell you things before they start, it takes time to build up a relationship and trust. They will get educational information but not more personal details. It would help to build the best programme for the student if they had the information. E.g. one student who had had her baby taken into care and that was one of root problems.

They need to know about any concerns. e.g. for work placements, but they don't place the student until comfortable with them.

Tutor OFE 002 42-50

Not all trainees communicate well or understand their diagnosis and I have gone to a GP with a trainee to help them. The trainee doesn't always know their diagnosis and, if it a trainer should have to tell them this is, it is not right or fair to the individual.

It depends on who is one's social worker, some are great others offer nothing.

OFE 002 100-104

I have been surprised that GPs do ring me back and they do respond and it is better than it was a few years ago when they didn't so much. I have been lucky with one GP supporting an anorexic student and he is concerned and he says 'what can we do?' and that is validating. If you are concerned you ring the Doctor and use your contacts, if you are snubbed it is not helpful.

Student Advisor OFE 005 165-170

Appendix 5 Healthcare support

5.1 Healthcare support

(There are no data examples to accompany section 5.1 of Chapter 5).

5.2 Primary care support

5.2.1 *Detection of problems and access to healthcare support*

GPs see a whole range of traumas e.g. students who have been sexually abused and those who have been raped (date rape is more common than we think) and such students are left traumatised. GPs see problems with drugs and alcohol, the police and which result in academic failure.

Personally, I would see about one or two students a year with psychotic illness. I am not sure how many are seen by the other partners but these few students tend to be regular attendees.

General Practitioner NHS 004 16-23

Most of the students are people trying to build up their lives. They are not all at crisis point, but are stumbling along and bring a lot of baggage with them. And then they are put together in an academic environment with lots of others with problems and we expect them to be successful. They do have the support of a counsellor which seems to be working better than previously. If 25% of XXXX's [name of institution] students are currently accessing the counsellor that is probably half of those who need it.

General Practitioner NHS 018 39-44

5.2.2 *Provision of primary care medical support*

Psychotherapy is a minefield, many GPs don't promote it. What if you don't feel a link with the first person you are referred to for therapy? And if that doesn't work, then what? And the short number of sessions is a problem. There is the need for at least once a month follow up sessions.

Student OXB S03 138-141

I sometimes think that some students are down in mood rather than being clinically depressed, but are prescribed anti depressants, which of course don't work, and I would prefer that they were referred for counselling first. There are quite a few students on antidepressants. It would be useful to conduct a survey of how many students are taking anti depressants. Many who have come for counselling have been taking them for at least 6 months.

Counsellor OXU 012 163-174

I tried to understand what is happening to the student and find out what the problem is e.g. is it the course? A relationship breakdown? Concerns with sexual orientation? It takes a problem solving approach if the student's problem is related to concerns over progression in career or course work.

General Practitioner NHS 002 112-115

If a patient likes you then you can push them into disclosure or taking medication, so without that, the professional doesn't get job satisfaction and the patient doesn't get very far in their treatment. However, you have to be careful in finding a balance between disclosing enough of yourself but not spoiling the relationship through transference. This is easier as a GP than as a therapist.

General Practitioner NHS 002 141-145

The GPs will agonise over the boundaries as to when they should get involved. You see the whole spectrum: some students come in because they have been in a fight or feel harassed by the authorities or landlords. In these cases, the GP can only listen. Some students will approach the GP to ask for a letter specifying that they need a place in a Hall of Residence because of their condition or a letter explaining why they are late in handing in their coursework.

I would like to think that I always help the student patient, but it is not always in the way that the student might expect. There may need to be some negotiation about the outcome.

General Practitioner NHS 004 99-107

Generally we manage quite a lot on our own, offering supportive help. We have a practice nurse who does brief intervention works and smoking cessation. And we have a counsellor and psychologist, but the waiting list is too long to be of use to the students.

Luckily we have a small practice list. The last few we had who were demanding were also time intensive, but we can give them time.

General Practitioner NHS 018 81-86

Students come back for ongoing support, usually 5 or 6 are coming in weekly to see me at any one time. Others are drifting in and out. I give 5 hours a week to counselling these students.

General Practitioner NHS 002 49-51

5.2.3 Referral from primary care services

Access to secondary care is very good. The CMHT will assess the need reasonably quickly, and there is ATA (Alternatives to Admission) which works very well. They already seem to know the chronic people. And of course they need to get a Section if things get serious.... On the urgent side of need, it is going well for service provision. They are no longer having to be sent out of the county for treatment.

General Practitioner NHS 018 136-141

I suspect in this practice we are quite slow at transferring patients and try out all sorts of things first. The outpatients service seems to be interested in trying out the latest antidepressants rather than anything more patient-centred.... As inpatients, what they do with them when they have got them is not always perfect, and you may get people seen by a succession of different registrars, but that is the way they are set up.

General Practitioner NHS 018 142-150

You need to look at the severity of the problem. If it is severely acute you find a way.

General Practitioner NHS 004 175

Due to secondary care waiting lists, many of these disturbed students are left to the college doctors who get the worst of it.

Counsellor OXU 003a 154-155

5.2.4 Collaboration with educational institutions

What can be frustrating for GPs is when students are referred by a tutor, when both the tutor and the student know the student has a problem but the tutor feels he/she needs the signed bit of paper from the GP to cover him/herself. Classically, this occurs after a bereavement when it is pretty obvious that the student is upset. On the other hand, it may be good for the student to talk to the GP about it.

The relationship with student services is important. Student Services are open with us and XXX [named individual] will call and say that x student is giving cause for alarm. You can ask the student to give their consent for the GP to discuss their problems with XXX.

Dealing with emergencies requires collaboration with the university.

General Practitioner NHS 004 115-118

GPs are funny, they should know about Peer Support, but I don't know what they know and how they see it. GPs should know about peer support through committees.

Counsellor OXU 013 144-145

GPs on the whole are very positive towards the students and have their well being in mind. I am often pleasantly surprised how much the GPs know about their students psychologically. The GP will see them soon or regularly if they are on antidepressants and are part of the holding operation themselves.

I don't think that the dialogue between GPs and the counselling service is easy or clear. Some GPs think the service is great others are not so sure. There is no template for how counsellors and GPs relate to each other.

Counsellor OXU 005 135-141

Coming back to the relationship with GPs, there can be mutual suspicion, the GPs that don't like counsellors and vice versa. There is frustration that the lack of time or commitment to working this relationship out, means that there is time wasted when students could have had the best of counselling and GP services. When the student is seeing both, I find it can be a case of trying to guess what the GP is working on, or finding out what are the effects of prescribed drugs. In these instances putting heads together could be helpful. One reason for me considering training in CBT, is that GPs will like it, it is seen as more scientific than other approaches. Perhaps the Counselling Service should be trying to educate GPs about what counselling can offer. There is suspicion about what you do from some GPs, but this is not true of all of them.

Counsellor OXU 005 182-199

5.2.5 Views on the quality of primary care services

The quality varies according to different GP practices. If I am not too worried about a student I may say 'why not talk about it with your GP?'. But if I am concerned I will request that they make an appointment with their GP and ask if I can contact the GP which gives the student a nudge to go. In the case of some GP practices, I have no clear sense at all of what they are like, it would feel difficult to ring them up because I don't know how they work. It varies e.g. there is one town centre practice where if I ring and ask to speak to a GP it is easy and they are supportive.

Counsellor OXU 012 140-146

In these cases [MH problems] I am looking to see what other support is available in the community but this is not always successful. For example I referred a female student with an eating disorder to a GP's nurse but it collapsed fast and the student never came back.

Counsellor OXU 004 94-96

The Practice tell the student that they don't have to register with them but they explain the benefits of doing so. Some choose not to and that may be because they fear that the university will find out their medical details.

The reality is that we are independent contractors. We have an agreement with the university but provide a confidential service. I will talk to XXX [named individual] if the patient consents or if there is a compelling need (usually risk of suicide).

General Practitioner NHS 004 123-129

There was the recent case of a schizophrenic student who did outstandingly well in exams – a good example of a genius who is also over the edge. It is a good example of how support can make a difference to a student as the student wasn't going to turn up for his exams. The college nurse got him out of bed and walked him to the exam room and also made sure that someone stopped him smoking dope and going out drinking after the each exam. Even on a large amount of anti-psychotic medication he had an IQ of 170.

General Practitioner NHS 002 60-66

Colleges are very supportive. Many of the dons have been through mental health problems themselves and are willing to agree that poor mental health is not a barrier to getting a good degree.

The Heads of Houses e.g. Principals, have not always come through the academic route. Their attitudes are not quite the same and they can be quite judgmental. They can feel that these students are disrupting college life and should go away and return later when they're recovered. Tutors in their 40s, on the other hand, have often been depressed themselves and have seen others get through.

General Practitioner NHS 002 154-161

The college doctors are superb. When the College has referred a student, they have responded quickly and, provided the student is willing to go, it does work out.

College Staff Member OXU 022 98-100

The college doctor is very good and supportive of student issues. Students can get a same or next day appointment and go through the nurse. There is one male and one female doctor and they seem good, providing an efficient and fast service. In a very busy period they had to wait 3 or 4 days but it wasn't urgent and if someone is at their wits end they will fit you in and they do make this clear.

Student Welfare Representative OXU S03 163-167

Obsessive compulsive disorders, phobias and depression will be open to medication through GPs. The Counselling Service feel pretty well contained through a good relationship with college doctors. They can put pressure on to get MH services at a higher level.

Counsellor OXU 007 180-192

My own experience of trying to access support through GP. You are aware of something, of needing support, and have insight. The GP will refer on to the School's counsellor, but if you are dissatisfied with OBU's or the counsellor's approach, and go back to the GP you will find the GP is reluctant to do anything about it. With putting pressure on the GP you find yourself referred to Littlemore and you get a full day's assessment which is frightening, especially as we have been taught how to use the assessment tests that are used! This also suggests a contradiction of confidentiality due to this being a common placement location and the possibility of meeting a lecturer practitioner whilst there.

So there is a jump from counselling to psychiatric services and GPs should pay more attention to what you are looking for. It is too impersonal which is not what you need. For me the MIND guide made me aware of other support routes. I don't think this situation has changed and another student has gone through similar experiences and pulled out of counselling because of the approach.

Student OXB S02 149-162

My original GPs were useless. I moved to a Beaumont Street practice as they were better because a GP specialised in eating disorders. I had bad experiences with the Warneford and the prescribed medication, the current GP knows about medication. Previously one GP said go back on a high dose of drugs which was the wrong thing to do. Some GPs don't think it is an illness so say 'pull yourself together'.

For the first 2 years after hospital GPs just wrote prescriptions on demand - based on the hospital's original prescription.

Student OXB S03 59-66

Concerning the quality of GPs, I don't know. Many college GPs are conscientious and if you know where to find them things are OK. It is difficult as some are extremely good. I know that the XXX [named] practice is highly thought of. GPs are confidential and I was lucky with one who helped, but the other was not so helpful. Some are also a bit suspect but supported by the system and hence covered up. My predecessor had a nasty experience with one of the GPs and wanted to include something about how to change your GP in the college handbook but the college removed it from the book before mailing. If you are unhappy with your GP they may be very involved in college politics so hard to change and you have to sort it out by choosing which one to go to. I wondered why the college hasn't replaced this particular doctor but have since found out that he is prominently placed in various committees. It is lucky there have been no tragedies yet.

When students ask for advice, I will recommend they go to the other practitioner. Luckily most don't need a GP and so you work informally with them and recommend a GP if necessary. I wouldn't indicate that a GP was poor lightly.

Student Welfare Representative OXU S06 241-250

We need more support from the medical professions. As calls will be made due to the seriousness of each case. The Doctor is also able to come and visit then leave, what happens to staff left on site? It is very emotionally draining and you feel obliged to take care of the situation. Doctor needs to ask staff if they are able to cope with the situation and provide support, not to expect that they will be OK.

Hall of Residence Staff Member OXB 010 124-129

Doctors are a nightmare as they don't want to come out. I have found that you need to get their name and then say 'in your professional opinion are you saying it is OK too leave this student alone?'. Then they will come out! Now it is Health Call and there is a doctor listening in. When I used this the doctor cut in and said 'get an ambulance now', so it may be that the problem with doctors has been fixed. I have not used this for a couple of years.

Hall of Residence Staff Member OXB 013 129-134

When you are in a situation any help you get is welcome. Doctors are not always willing to come out. Students are not always given the medication they feel they need e.g. after not sleeping for 3 or 4 nights.

Hall of Residence Staff Member OXB 016 158-160

Access to the service's own consultant is OK. I get the impression that in the community there is a waiting time which could cause problems. There are issues around treatment e.g. the medical approach to life problems – students coming to the service who have been given tranquilisers by their GP. The University Medical Centre did have a well-resourced mental health team with a variety of different forms of psychological support. However, due to the Primary Care reorganisation, much of this has been lost.

Counsellor OXB 002 128-137

In the case of the student with depression, I have access to the counselling service's psychiatric consultant and feel supported there, but don't really know what is available if the student was deemed to need further intervention. The student has not had counselling before but is on Prozac - why has the GP not offered anything else apart from medication?

Counsellor OXB 005 131-135

I had one student client who had psychotic symptoms. The student had booked an appointment with her GP because she was not sleeping well. The student's English was not good and so I contacted the GP because I wanted the GP to check for psychosis. I left several urgent messages with the GP but got no reply. I finally got through a week later by which time the GP had seen the student and had missed the symptoms. The student was later given an emergency admission to mental hospital.

Another time, a GP did get back to me on a case and it did work out (the student had given permission for this contact). So there is a need for closer liaison, so that counsellors and doctors can talk to each other. At present there are no joint meeting opportunities.

Counsellor OXB 006 131-141

It is one thing working with a GP who is sympathetic but another when you get those who are not. It is very difficult to get help for those with more specialised problems. A shortage of places in therapeutic groups, psychology and psychotherapy. How many clients can I think of as being in this gap category? I can think of 4 definitely, 3 are being seen and one has been referred back to the doctor who has been quite uncooperative, had tried referral to the Warneford without success. I insisted that the doctor gave a psychiatric assessment, he was uncooperative and she (the student) was splitting between two doctors in the same practice. The doctor concerned was not psychologically minded. It was a great pity as she needed profound help. Some doctors take the attitude that they know better and there isn't a problem. They can be wanting to be in control for the best of intentions and it is not helpful for students. And yet it can be collaborative and there can be a dialogue, which for the students can be like parents talking to each other. Thus it is reassuring for the student to be held and to know that there is co-operation.

A problem with building relationships with GPs is the number of locums who come and go.

Counsellor OXU 016 41-56

Things usually work if it is just a referral to the GP that is needed. If the client is already seeing a counsellor, I would usually say that it would not be appropriate to see me as well. If the client is seeing either a psychiatrist or a psychologist I would negotiate what could be done.

There have been tensions in the past, although now XXX [named practice] has changed again, when I have sent a client to a GP and the GP has referred the client to a CPN without negotiation with the referring counsellor. Such students might either disappear or reappear at the counselling service stating that they are waiting for a psychiatric assessment. I would like other professionals to be courteous and professional and consult with me about such referrals with the client's permission.

I have not been aware of psychiatric referral to student counselling within the city but students from elsewhere may be referred by their therapists.

There are some referrals that are inappropriate for example from academic colleagues who refer students with severe mental health problems to the counselling service. This is worrying for the counsellors and worrying for others. Such students then need to be referred on from the counselling service via the GP. Such inappropriate referrals are confusing and time wasting for the student.

Counsellor OXB 009 162-179

5.3 Secondary and tertiary mental health services

5.3.1 Access and referral to secondary and tertiary medical support

5.3.1.a Psychiatrists

Students are a privileged minority but they also have special needs to do with the timing of services. I would like much more immediate access with psychiatrists going in and psychologists providing CBT. I would like to see a dedicated student service with almost immediate access.

Psychiatrist NHS 001 103-106

I only deal with the severe end of mental illness. Most of the students on my patch are from Brookes. Severe mental illness covers affective disorder, schizophrenia and very severe neurosis.

Psychiatrist NHS 003 7-8

Because I am only brought in at the severe end of mental illness, it is difficult to comment [on the range of MH conditions amongst students]. I haven't seen many eating disorders considering that they must be common amongst students. It may be that such students are being seen by other practitioners.

Psychiatrist NHS 003 20-23

I mainly deal with psychosis, those from the most severe end of mental health. I see those who need a high level of care e.g. those students coming to hospital or needing a high level of support in the community.

Psychiatrist NHS 006 35-37

I don't have a waiting list. If the GP says I want XXX seen next week it will happen and I will ask the GP what they want from the assessment. There may be a point in that do they need to see a psychiatrist? We don't run away if they are referred, but if they need a psychologist there may be a delay.

Psychiatrist NHS 006 161-164

We can't see everyone and have reasonably strict criteria. They have to have a serious mental illness, we don't treat those with behavioural problems, or those who need bereavement counselling, so other services are needed for those people.

Psychiatrist NHS 022 84-87

Perhaps those who are potentially very seriously mentally ill are referred the earliest and it is true that there are a number of false positives relating to this i.e. those who might be psychotic turn out not to be. This is an example of a GP erring on the side of caution.

Psychiatrist NHS 003 42-44

Although I believe that the university counselling service is good I would also welcome access to psychological counselling through the primary care route rather than waiting for the student to need referral to the psychology service later. More intervention/psychological input at an earlier stage may enable their problems to be dealt with at a mild to moderate level rather than severe level. This is not so much a psychodynamic or CBT choice but a need for earlier intervention via a college GP.

Psychiatrist NHS 006 153-158

5.3.1.b Nursing staff

Students often present through a counsellor or through GPs; often it is the GP. St Bartholomew's Health Centre is linked to the Ward. GPs will refer their patients to outpatients for assessment, but if there is a crisis then it is likely to be urgent assessment for admission or possibly a Section.

Psychiatric Nurse NHS 015 35-38

Very ill students probably won't access counselling if they are feeling they are going mad. If they have got to the point of being severely ill they need to come here. There must be those who don't access this treatment who need to, those who are shut away in their rooms.

Psychiatric Nurse NHS 015 84-87

We have quite a few students on the ward at the moment. A couple of medical students, philosophy students, an arts student has just been discharged. Nearly all are in age group 19 to 28. Probably 60% have psychotic diagnosis, the other 40% will include bipolar disorder, depressive episodes and personality disorder (we have two students in with that at the moment). I know of three student patients who have experienced a schizophrenic or schizo-affective disorder for the first time.

Psychiatric Nurse NHS 026 11-16

It is sad that acute provision is in a hospital setting and sad that hospital is seen as a last resort rather than as a good place for treatment. It is seen as a last resort by many users. Hospital settings have gone down in what they can offer because of the emphasis on community services. And so people feel bad about being in hospital because of the government emphasis on community services.

Psychiatric Nurse NHS 026 34-38

5.3.1.c Mental health service managers

In terms of the client group, our job is to meet the needs of the locality and students are a big group and we need to ensure that they have equal and equitable access to services. However, they are competing with other vulnerable groups.

Clinical Manager NHS 014 13-16

I imagine that waiting times for psychotherapy is a problem for students (I don't manage the service). And this is a group that is assessed as needing more. The waiting time for CBT is about a year. It is frustrating in that, if you can have a positive effect now, it might reduce the need for services later.

Clinical Manager NHS 016 30-42

There are problems particularly with access to Psychology and it is difficult in that Psychology doesn't seem organised to make the maximum use of clinical time. It is not a huge resource and has conflicting priorities. Psychology provision will always be an issue.

Mental Health Service Manager NHS 014 84-87

I manage the social work, administrative staff and CPNs. So any contact with students is through referral and discussion with GPs. We have students from Brookes working with us, those on social work and nursing courses, so that could be a big issue if any needed treatment. Very few would be in that position.

CMHT Manager NHS 027 8-11

Patients are referred by their GP. Generally as a team we aim to look after people with severe and enduring mental illness and aim to help primary care look after the simpler mental illnesses and so we would hope that GPs would have tried to treat depression unless it was very severe and would only refer if it hadn't worked.

Sometimes the criteria are not adhered to, it is supposed to be severe and enduring mental illness but we do see people in crisis with less severe conditions. I think GPs are generally clear but there has been difficulty with the PC counselling and psychology service not accepting referrals due to staffing issues and that has probably led to some referrals to us. It is difficult with patients that fall between the 6 sessions that the PC counselling can offer, whilst not being ill enough to be treated by a CMHT.

CMHT Manager NHS 027 25-32

5.3.1.d Clinical psychologists and psychotherapists

If someone was acutely psychotic, or using drugs and alcohol a lot, I would say that it is not the time for CAT, as they would not be capable of taking it in. So I would advise that they should tackle the addiction problems or seek medication for psychiatric problems. We discuss criteria in assessment meetings and some say it is about 'psychological mindedness'. You need certain level of motivation and someone has to have at least a minimum ability to think about things.

Psychotherapist NHS 017 28-33

I will get referrals from colleagues in the team, and some direct referrals.... I also take on clients if I already know them and they have had an episode of care with us and the work is not finished or something else has happened to them. Referrals are made to me if psychological interventions may be helpful or if there are complex issues to be resolved before the person can change their substance misuse.

Clinical Psychologist NHS 021 29-35

A lot of referrals for psychology are from GPs or from SHO's [Senior House Officers] in psychiatry who are seeing the first line of referrals.

Clinical Psychologist NHS 024 107-108

Usually the referrals meeting will have identified patients who are likely to benefit from CBT (i.e. the evidence is usually for anxiety disorders, including OCD, depression, bipolar, psychosis). Those who are able to self-report, are willing and agreeable to try different management strategies and are able to generate goals for change, are often considered appropriate.

Clinical Psychologist NHS 024 44-48

I am a Consultant Clinical Psychologist for adult eating disorders. We take secondary level referrals from CMHTs. The patient will have first gone to a GP who refers them to the CMHT, if their condition is severe then secondary level services will refer the patient to us [tertiary level].

Clinical Psychologist NHS 025 6-9

5.3.1.e Other respondents

At the formal level, the referral to mental health services is very difficult. There is a waiting list, of ten months for Psychology? With such a delay the support practically isn't there. They do not see students differently to anyone else but due to 3 x 8 term structure the student won't make it to treatment in time.

The mental health service deals with the severe end of mental health and doesn't see the counselling service cases as serious enough. Sometimes a psychiatrist will take over and whisk the students away. This is a relief in some ways but the counselling service sometimes wishes that they would be consulted e.g. when the student is put on anti-depressants and they don't turn up for their next appointment, it would be nice to know why.

Counsellor OXU 004 127-136

The main problem is the lack of places/ resources to make available when referral is needed. It is very difficult. There is a gap for those who are in the middle between counselling and emergency admission. There are many students with problems who, if the support was ongoing, could have remained at their studies. I wish there wasn't such a long waiting time for referrals for other mental health services.

Counsellor OXU 012 197-201

It is 'sticky' when someone needs to be seen quickly and the doors are closing for example the Warneford's Clinical Psychology Department is only taking the seriously disturbed. Likewise the CHMTs are only dealing with those who are most severely affected.

There is a gap for those in the middle who would benefit from being helped. The counselling service occasionally do help such students, but capacity to do this is limited and spaces are soon taken up.

Counsellor OXU 008 176-182

There are very severe criteria for obtaining further treatment for eating disorders, and the treatment is not compatible with being a student, as they have to attend a clinic every day. A student would have to go back home to get the treatment. I like to see a better service. There is a chronic and appalling lack of provision. It should be possible for them to get treatment.

Counsellor OXU 009 65-69

I have only once succeeded in getting someone committed. The student in question was working on security on site for the vacation conference season but had totally 'lost it'. I phoned Social Services saying 'it is either her or me – I can't take any more of this'. A doctor came out but the student hid and that went on for weeks. She wouldn't speak to men.

Hall of Residence Manager OXB 010 99-103

5.3.2 Provision of secondary and tertiary medical support

5.3.2.a Psychiatrists

I use standard procedures. I am looking for serious mental illness and a risk of suicide. I will assess the student as part of a team and see what the team can offer.

Psychiatrist NHS 001 40-42

I do what I was trained to do. I carry out a standard assessment, the interview covers a wide range of issues. I see clients for about an hour.

Psychiatrist NHS 003 29-31

The service uses standard psychiatric practice. There is assessment of the individual and the family. We try to get information from the client's school. Then there are other standard psychiatric interventions providing support to the individual, perhaps some CBT, family therapy and group work occasionally. There is also pharmacological treatment for some.

Psychiatrist NHS 013 24-28

[What do you offer?] A first assessment. A shared understanding of what is going on. A diagnosis. Treatment. This may be medication or sending the client to someone else for psychological treatment. The two can happen together.

Psychiatrist NHS 003 55-62

[What do you offer?] Assessment. A range of interventions including medication.

A team approach to the person.

Psychiatrist NHS 001 69-71

If I had a patient who had a social problem, I would refer the client to a social worker for a social needs assessment.

Psychiatrist NHS 001 123-124

I provide assessment and treatment for the [adolescent] outpatients. I work with a team which includes a psychologist, an OT, a CPN and a social worker. I work with individuals using CBT and Family Therapy. I am also involved with group work on issues such as anger management and communications problems.

Psychiatrist NHS 022 12-15

We need more CBT as it is effective for many conditions and isn't as long term. You don't have to go into all the business about 'how did your father treat you' but you can identify the problems now and work on solving them. If therapy is not working, it shouldn't go on for months or years, but it does with the psychoanalytic approach.

Psychiatrist NHS 001 111-114

The CMHT have links with the academic outpatient department, the Department of Psychiatry. Back in the days of Professor XXX, the Department tended to take referrals for students with study problems. It is now run by Professor YYY and if needed we can send a proportion of patients to them, including students. Quite a few students will go there since the Department has an understanding of the academic implications of students' lives.

Psychiatrist NHS 006 16-21

There is ... a problem over residency of students. The students come from their home town and register in Oxford with a GP. As a CMHT you have a situation where a student is living elsewhere but the GP will ask 'can you see x who is living in Lincoln?' There is a need to be clear if the student has a dual link. The CMHT take the view that the service should be provided locally where the student is living and look to the student's local psychiatrists. If we have had contact with the student, then we will personally ensure that there is a transfer and that the student does qualify for CPN input locally at home. It is possible to stay on the waiting list for psychological treatment in Oxford and have ongoing care at home.

Psychiatrist NHS 006 118-126

There is a concern that statements about services to students don't reflect the effort that is put in. Perhaps it is more true of those waiting for psychological services rather than those with psychosis. Perhaps it is also linked to suspicion of psychiatry and the view that it shouldn't be necessary?

Psychiatrists NHS 006 141-144

5.3.2.b Nursing staff

The assessment is ongoing. First by GP, then often outpatients and then and, if admitted, assessment by the doctor on duty. Then nurses become involved, there will be a named nurse allocated, and the OT, so it becomes multi-disciplinary. The nurse will write notes each day and the assessment is ongoing.

Psychiatric Nurse NHS 015 47-50

We assess and help them move on and we get people who come back. The acute nature of the work means we are helping the patient to deal with the crisis and move on.

We have a lot of people with social and especially housing needs. The nature of their illness affects their ability to keep lodgings. And so we end up dealing with the social problems which affect them.

Psychiatric Nurse NHS 015 12-17

We are dealing with acute distress, so they are in a state where they are not functioning outside, and we are trying to gain their trust. We try to see what their needs are and what is going on.

Medication could help although it is not the only answer.

If they are willing to be here it is easier. If they have come in on a Section more work needs to be done on developing trust.

We observe and monitor and gradually get them involved in groups and activities. There is drama therapy and art therapy through which they can become involved with others. There is a multi-gym which get their level of activity up, this can help with depressive illnesses.

Psychiatric Nurse NHS 015 54-63

In the case of those who are in for a long time, we would be looking for some other external therapeutic input. Use of techniques such as CBT are not formalised on the Ward yet, but that is something that could be developed. Most nurses have good nursing counselling skills of generic type. If patients need psychotherapy they can be referred on.

Psychiatric Nurse NHS 015 68-72

It is about helping them, they may want to keep their home environment separate and clear from their mental health problems.

Psychiatric Nurse NHS 026 39-40

5.3.2.c Managers

In terms of the client group, our job is to meet the needs of the locality and students are a big group and we need to ensure that they have equal and equitable access to services. However, they are competing with other vulnerable groups.

Mental Health Service Manager NHS 014 14-16

The service has been looking at the impact of students and when they present to services in relation to designing our workforce plan (linked to quality of working life initiative). We are looking at the feasibility of offering some term-time employment which might attract new staff in, helping to overcome recruitment problems in Oxford. This could help to meet the increased demand for services in term time. The employment of a specialist consultant psychiatrist for students in city was considered, but the feedback is that people like the variety of working with different groups....

Although there is a need for term time services, it should be noted that there are students who come back for treatment in the vacation. Having started they need to keep going.

Mental Health Service Manager NHS 014 29-42

... we know that students are a needy population, a risky population. Although not wanting to contradict what I said earlier about staff wanting to work with a variety of clients, you don't want to dilute the experience of working with a particular group and gross assumptions can be made about students, but they are high risk group.

Mental Health Service Manager NHS 014 112-116

5.3.2.d Psychologists / Psychotherapists

The therapeutic approach is decided at the assessment stage, it might be CBT for a phobia or OCD. The CBT approach can be used for severe conditions but ones that have something identifiable to work on.

If people are showing problems and there is an underlying difficulty, CBT may not be appropriate, as other symptoms may emerge if we don't address the underlying problems. It is often to with relationship issues that have their roots in the past. One could think of psychodynamic therapy, or group work, or CAT for these cases. Those who are referred for CAT are often those who have personality type disturbances. They may be chaotic, self harming, taking overdoses, or experiencing powerful mood swings.

CAT helps in that it is clear and structured, with a clear time boundary and a very clear set of tools e.g. writing narratives and using diagrams which can help people to step back. It addresses the present and past relationships and sequences.

Psychotherapist NHS 017 49-60

It is when that structure is felt to be needed that CAT would be recommended over a group or psychodynamic approach where the therapist is less active.

We also have people come with depression. They may come after having tried CBT which may have helped at the time but they could not keep it up in practice, or could not hold on to it, and there is something underlying the symptoms that needs to be addressed.

Psychotherapist NHS 017 65-70

Psychiatric teams are very busy and they have the need to work on a rapid turnaround basis. Even though the psychological approach might be helpful, the pressure is such that it could be considered to be too slow, and yet I think it could save them time.

Psychotherapist NHS 017 137-139

I have several models which I use – you could say it is an integrated approach?

It is about helping people bringing about changes in their lives over three timescales:

- The present. How they are regulating their internal environment. Their problems in the here and now.
- The future. What they are doing starting from the rest of today and tomorrow to bring about change. We know that this is important.
- The past. They are often bogged down in that it is difficult to get out of addictive behaviour because it has advantages for them in their thinking, feelings and actions.

Often people have had an early history of abuse leading to difficulties in emotional or other developments, or their problems may be related to trauma. Some are very vulnerable, overwhelmed with stress. I see how I might empower them to carry on coping in their own style, but to enhance that style.

I use CAT as it is very useful to explore how they got into a pattern, to make sense of it and give them a self of self.

I use CBT to help with goals for the future and to link how they are feeling to thoughts and behaviour. Looking at what already helped in a situation and how to harness more of that help.

Also Brief Solution Focused Therapy to look at a time when they were experiencing better states, what they did then and what they could reactivate now.

I also use motivational interviewing techniques. We ask them the question: how could things be better and what could they do about it?

Clinical Psychologist NHS 021 96-117

Where does my role fit in with a bio-psychosocial model? There so many issues influencing addictions including government policy and social attitudes. I am trying to focus on my bit or contribution and to bear the other bits in mind. I have two colleagues in psychiatry and we see some people jointly, especially where it is important for the person not to seek a 'miracle' medical solution but to get them to seek their own solution and change their behaviour.

Clinical Psychologist NHS 021 138-143

People with personality disorder, those who are psychotic, they are all part of one population. Some may like to see me and some want to see another person they know in another service. One thing we know is that the quality of the relationship between therapist and the individual is the main success factor. You can't always match people to different approaches. This is one reason for using so many types of approach, to find what works. I am interested in systemic work which looks beyond the individual.

Clinical Psychologist NHS 021 164-170

[What do you offer?] Mainly CBT, although our training incorporates a breadth of different models and therapeutic styles from which a practitioner may draw. CBT, put extremely simplistically, helps to change unhelpful thinking patterns and unhelpful behaviours/ management strategies that may have developed as a result of early (or later) experiences. This approach integrates well with other psychotherapies and it is not uncommon to involve relatives and carers. Essentially we are guiding clients to find more helpful ways of managing their specific difficulties.

Clinical Psychologist NHS 024 53-58

Once referred to a CMHT, access to treatment depends on the team. This team is pro CBT but anti the long wait for it. If a student presents in their 2nd or 3rd year they may not have time to start treatment and may have to rely on antidepressant treatment etc. In CBT people can be worked with who are medicated. My recent experiences of treating those without medication show that it can be difficult if they have to wait without having anything. It is worth trying antidepressants although CBT can be seen as an alternative to medication. CBT is also used for psychoses.

Clinical Psychologist NHS 024 89-95

They can be offered 9 months treatment in 3 months blocks. This is for 4 days a week with a gap on Wednesdays. It runs between 8.30 and 4.00 with breakfast and lunch. There are a whole lot of groups: life skills, coping skills, self-esteem etc. The feedback is quite good. I guess that more students would turn down day patient treatment than accept it, but a significant minority do accept it, both undergraduates and graduates.

For those in day treatment we offer further assessments with a family therapist and some with a dietician. This is to look at family issues and dietary history, and to look at meal plans in detail. Each week they meet for 4 days with an intensive programme of group work and activities. There is a range of therapies including sessions of dialectical behavioural therapy. This programme will be common to day patients and the new inpatients. In addition they have once-weekly individual therapy and would be offered family therapy sessions. The latter can be difficult for students with family elsewhere, but some families will travel considerable distances to participate in this. These sessions can be helpful for families to understand what they can do to support the student during the vacations. Day treatment is offered in 3 month blocks.

There is the outpatient service which offers individual therapy sessions. Depending on individual need the length varies. We try to keep to some time limit, but by the time they come to us their condition is quite severe. 20 sessions is the aim, but that often has to be extended. Patients get 20 one hour sessions of CBT on a weekly basis, and there is a regular review of progress.

Clinical Psychologist NHS 025 67-87

The typical situation of needing to engage another service is co-morbidity with the eating disorder, e.g. depression or substance use. We would contact the CMHT or Substance Abuse unit about this. Typically for co-morbidity there may be a personality disorder and we would work with the new complex needs service developed by the Psychotherapy Department.

If a student has housing needs we might refer them to the CMHT for help with housing, as we do not employ social workers.

You usually encounter some problems working across services. It is not ideal, but they are not massive problems. The main problem is if the student is not motivated to engage with services. We try to liaise well and to keep the student's needs in focus and not make it too bitty.

Clinical Psychologist NHS 025 210-220

5.3.3 Students' use of other agencies

I will put the student in touch with a voluntary counselling service if the presenting problem is related to bereavement e.g. Cruse.

General Practitioner NHS 002 47-48

We try to ensure that they get other support when needed. It is difficult with cutbacks in services. They may try for Social Service support but that has diminished. Connections is a good service and the Unit do make links with schools and colleges or vocational training providers.

There is a lack of follow-up psychiatric services for those with psychoses, that is particularly poor. It is not there.

Psychiatrist NHS 013 75-80

There is a need for more services that help to move people on rather than just filling their day with activity. There are opportunities e.g. involvement in sport, but a shift in culture is needed. We tend to have more day activities than moving on opportunities.

Mental Health Services Manager NHS 014 72-75

Oxford poses problems in that we have set up the Assertive Outreach Team and many of their clients don't want to go to somewhere for 'mad people', they want something more normal, so they won't go to somewhere like the Learning Centre.

A model that fits people in assertive outreach would be to provide the support where they are, and not to expect them to come in to a centre.

Mental Health Services Manager NHS 023 97-101

5.3.4 Supporting the integration of student patients into academic life

5.3.4.a Links with academic institutions

It would also be good for students to be able to do academic work in hospital if needed. Sometimes though, they can't recover and study at the same time and need their institution to keep the door open. At least Brookes is modular and can cope with different paces of study.

Students with mental health difficulties need suitable accommodation, MIND and Stonham group homes are not suitable for temporary residents like students.

Psychiatrist NHS 001 117-122

The people we have contact with are doing the best they can. XXX [named individual] at Brookes is very good and follows things through and comes back to us.

The stigma is a problem.

Psychiatric Nurse NHS 015 169-171

XXX [named individual] at Brookes was always very accessible and would come up and visit at the hospital and that was very helpful.

Psychiatric Nurse NHS 026 106-107

The academic institutions have been more helpful than unhelpful. I haven't heard of any great difficulties and XX [named individual] was always a good link. We used to have one nurse linked to YY [named medical centre] practice and that helped as she knew XX. Our consultant knows him too. There

is now not so much of an official link to the GPs. We are looking at restoring the connections, so that will help.

I am not sure that getting the student's personal tutor involved in their care happens enough. Perhaps students don't want them to be involved. We don't have so much of a link with tutors, but if the student was seeing a university counsellor we will contact them.

Mental Health Service Manager NHS 027 55-61

Over the years we have had people become ill in the halls of residence and there have been complaints about them from other students. Questions are asked about how long will they stay and are they a risk to the other students?

I have known students being asked to leave halls and XX [named individual] went out of his way to find them other accommodation.

Mental Health Service Manager NHS 027 66-69

The student was let down by the Brookes Housing Department. The situation seemed hard as the student only had a few weeks to go. He was living on the ward at the time and going to lectures in the day. He didn't make it and after being turned down for housing he went back to his family. The ward really wasn't a suitable place for him. He did damage university property and didn't answer letters from Brookes about disciplinary hearings. XX [named individual] was good and did what he could, but he couldn't do everything.

Psychiatrist NHS 001 15-21

Sometimes the problem is the effect on others, the nature of the institutional environment. Exhibiting disturbing behaviour in college is very different to being in one's own flat. As well as being a hothouse environment, it is very public. There will be a 'spectatoring' of the student's behaviour and the student may be aware of that and be affected by the stigma. It is for this reason that students don't want the CPNs visiting them in College.

Psychiatrist NHS 006 86-91

College staff probably have a fear of raising the problem [eating disorder] with the student. There is a gap now that the University of Oxford's Eating Disorder specialist has left the counselling service. The Unit has relatively little contact with college staff. There is some contact with college doctors, and very little contact with college nurses.

Clinical Psychologist NHS 025 160-164

Guidelines on university procedures for accommodation and leave following illness would be helpful for us.

Psychiatric Nurse NHS 026 132-133

5.3.4.b Developing systems for collaboration

What would help would be to have a student link person on the ward and vice versa. The student's case would be discussed between staff. It could be that the link person could refer to the named nurse of that person.

Psychiatric Nurse NHS 026 114-117

A dedicated student mental health service versus the current sectorised service? It would be difficult for psychiatrists as they would lose the connection with GP practices and hospital beds, it would involve a confusing amount of liaison between consultants.

CPN input is a different model and might lend itself to this.

Psychiatrist NHS 006 165-168

My own experience is that there are good contacts and channels of communication and these are often to do with personalities. We can all learn to work together better.

What helped when working in City Central CMHT was the idea of the network, so if there are concerns people would know who to contact. It is worth looking at making links e.g. dedicated CPNs with particular college nurses, so things can be flagged up sooner rather than later. However, the relationship and trust built up with the student is important, and you must be careful about getting into talk of psychiatric services too soon. These links would be about ensuring communication both ways and the CPN could use them to tap into what is available. They have tried it with GP practices and it has worked with some.

Mental Health Service Manager NHS 014 53-62

These things are more and more important as things develop with a community focus. People will need to know about what services to access. With the emphasis on supporting people in the community, it is important to keep people in their educational institutions and those networking events are important for that. Without it we could get back into students falling between two stools e.g. do they go to counselling or mental health services? And it is about raising awareness for both sides.

Mental Health Service Manager NHS 014 134-139

Unless there is someone with a concern for student mental health priorities, they will get lost among all the other competing demands. So it is only achieved by having a champion who can get people to look at the issues and advocate on behalf of students. There needs to be someone to permeate the boundaries of organisations, you need people to work alongside service and other staff. To get things done you need consistency in staff groups and you need to build relationships. It is the links that are important, the same as for GPs who link to clinicians, and you can get them to do more that way.

Mental Health Service Manager NHS 016 58-65

There is a need for a post like a community mental health nurse within the university. I am aware that I am dabbling in the situation but am not the best placed to deal with mental health problems.

Hall of Residence Manager OXB 010 120-122

It is important that people do different jobs with such students, but communicate with each other. There is a need to assess if a full time place is necessary for students with mental illness? It is necessary to build up a care package that is integrated, with people communicating about the issues. In some cases you would need to deal with confidentiality issues. You need to think about the timing of the studies. Are they ready to start now? Do they need to start in a small way. To take an approach of 'let's all talk about what is possible'. Most patients etc. would rather start from a manageable sized commitment than take on too much.

Counsellor OXB 003 155-163

5.3.4.c Sharing information

Collaboration between academics and health teams – I feel that the Head of Student Services is very good and helpful, coming up with good information. The point is to get information from the educational institution and to provide it to them, if the student is willing.

Psychiatrist NHS 003 81-83

How do you know as a medical practitioner, who to approach in a university or college? I feel that this needs guidance. Information sharing also works the other way e.g. if a tutor knows a student has a mental health history and he/she is worried they should be able to talk to the mental health team. The tutors need to be alerted when things are going wrong.

NHS 001 91-95

The student who is a patient will be reviewed after a ward round and there would be a meeting before discharge. However, it would need the student's permission to involve others and they may not want family involved. Upon discharge they might be allocated a CPN, but usually it is back to the GP, it depends how bad the illness is.

Although staff back in the academic institution may want information, health staff are stuck in not being able to say anything without the patient's permission. They will follow up with out-patients appointments. Depending on the severity, the frequency of these will vary.

Psychiatric Nurse NHS 015 132-139

If they have high risk behaviour then you would have to alert others. People at the other end are quite anxious and are looking out for problems. Staff would have to sit down with the patient and say 'do you mind if any information is shared with someone at the university?'.

Psychiatric Nurse NHS 015 140-143

In the absence of medical staff on-site (as at Brookes), other staff may need to develop a way of getting a student to seek help. This is a skill and they would need training in this, as it is not easy. Hall wardens and personal tutors could have a role in this.

Clinical Psychologist NHS 025 202-204

If you approach the counselling service, you can be seen as an outsider e.g. in the case of a female student who went into hospital. She doesn't come into college much. It is perceived that she has had to get medical help. There is a stigma which gets attached to you once you do that.

Student Representative OXU S05 165-168

The student was voluntarily sectioned, but there were not enough secure beds so she let herself out, and staff made contact with the hospital and she went back. Then when she was released properly from hospital, the hall staff were not told and a flat mate saw her go into her room with a bottle of alcohol and this is the only reason she is still alive. As hall is the place where the person is living shouldn't staff be informed when such students are coming back?

Hall Warden OXB 013 108-113

5.3.4.d The roles that staff in HE/FE could play

There will be those tutors who are supportive and those who are the opposite. And providing support is a balance that tutors have to work at with all the demands on them.

Psychotherapist NHS 017 177-178

The tutoring systems can work well or not so well. Some tutors have been very caring about students I have treated and we have been able to liaise in a helpful way e.g. in the case of a suicidal student who was very able but doubted herself, collaboration with tutors worked well.

However, it depends on the personality of the students and tutors involved. In pastoral care the better the relationships the better the care. Staff vary and Oxford has a lot of eccentrics. Some post-graduate students in treatment said they like being at Oxford as it is OK to be eccentric here!

Clinical Psychologist NHS 024 145-152

5.3.4.e Working with particular colleges/ universities

With some clients you can wonder how they could have been selected, why were they admitted to the university when they were obviously not well? It is difficult with accessibility to education being widened and not wishing to discriminate.

Mental Health Service Manager NHS 014 126-128

There is a problem with the College being sort of in loco parentis e.g. a college may have a problem with the behaviour of a student with a personality disorder due to drug or alcohol abuse but the student may feel they don't have a problem. The referral may seem to be from a care perspective but there can be seen to be a degree of coercion in that if the student doesn't attend or progress e.g. persistent self harm, they may not be allowed to continue at college.

Psychiatrist NHS 006 92-97

Additional problems can occur when parents' input is needed e.g. due to a suicide risk or if the student faces being sent down for a year and needs to be sent home. Some students will refuse contact with parents and I then face a complicated three way situation involving GPs, colleges and parents. Where parents cannot be involved, it may be possible to tolerate a higher threshold of disturbance before the students have to leave, but it lowers the threshold when dealing with self harm, aggression, romantic harassment or stalking behaviours. Although technically adults, many students are still dependants.

Psychiatrist NHS 006 98-105

The average length of stay would be 8 or even 12 weeks, so they are away from their course at university. In their last couple of weeks here we make sure they are ready to leave. If as a result they have to take a year out from their studies that will have an impact on them, another loss. If they have a depressive episode and then the college says you must go back to do a term or a year again, it doesn't help their motivation and they may feel in a rut. One person didn't go back to their studies for that reason. It is such a major life event to be in hospital and to be told that you aren't wanted at the end of it is hard. Having to take a year out of university is a barrier. Oxford Brookes are very good at meeting students' needs.

Psychiatric Nurse NHS 026 56-63

There was a student seen who struggled with attending large scale lectures and has moved on to the Open University. He already had Aspergers and then had a psychotic first episode. They have been very good with him and arranged for him to take an oral exam over the phone. This could be seen as avoidance of something that he should be supported to cope with, but it helped him to get through.

Clinical Psychologist NHS 024 158-162

5.3.4.f The role counselling services following discharge

They go to the CMHT after discharge and hopefully get the support they need. I would be surprised to hear that they had been discharged to support from a university counselling service.

Psychiatric Nurse NHS 026 144-146

University counselling services are very rarely seen as an ongoing source of support by our student patients. They may have tried them before being referred to us, they may have concerns about confidentiality when using a university-based service. The university counselling services could be useful to them if they had specific academic-related problems.

Clinical Psychologist NHS 025 228-232

It is helpful to know that their educational institution has counsellors. They, and a tutor system which encourages people to talk about their emotional needs, would be very supportive for our client group. When the clients move on post-18 they will often still have links with the health systems and we will refer them on to a CMHT. Unfortunately the level of support, including psychological support, drops when they enter adult services, so additional support would be very helpful at this stage. Some want a fresh start and might not want to be linked into support services, but it is useful to have a safety net. Even if they don't use it, the knowledge that it is there would be helpful. Having no safety net on entering further and higher education could be quite anxiety-provoking.

Psychiatrist NHS 022 62-72

I would also check if someone is in treatment elsewhere and how that would affect how to work with this student. If a student is seeing a CPN or psychiatrist, it is not a problem if all are aware. The counsellor is looking for what might be a conflict for the person when they are receiving more than one form of support.

Counsellor OXB 008 25-28

I have had a couple of people referred from the Warneford with mild personality disorders or manic depression. Such students are long term ill but are referred in order to deal with the social aspects and interpersonal problems that follow on from their illness, rather than trying to effect a 'cure'. In this case the sessions might be dealing with helping them to work out how they fit into university life and how to have a social life. This is necessary because of the isolation that has resulted from their period of ill health.

Counsellor OXU 003 235-241

What is the link between the university counselling service and the mental health services? It seems to be a case of 'it is over to you', once the client is accepted as a student. My experience is that services which are under pressure, readily shift people on. If the university takes a student with severe mental health problems, the institution needs to feel supported and not dumped on. Counsellors are not psychiatrically trained nor are they an emergency service.

Counsellor OXB 004 223-228

There is a source of anger that a student is discharged by a junior doctor or registrar to the counselling service. The counselling service will often receive a letter out of the blue. There is an assumption that the counselling service will have the time and space and that they don't have to agree to the referral. This happens to me approximately once per year. Discharges such as these also occur from the Barnes Unit.

Counsellor OXU 004 144-149

Mental Health Teams are too stretched, and I feel their reaction is that 'if you are coping with a suicidal student good luck to you'. E.g. the student who has an overdose and goes to the Barnes Unit and then comes back to counselling without any liaison. The Unit will communicate if you seek it out, but are too stretched to offer ongoing support. So if someone is discharged it is back to counselling. If the problem is severe the service can't cope so the student is off their hands and back home.

Counsellor OXU 005 142-147

5.3.4.g Input from mental health services

We point out on discharge that the patient should not go back straight away to studying....

People can go to their university lectures in the day and come back to the Ward in the evening for a bit.

Psychiatric Nurse NHS 015 140, 172-173

Ongoing CPN support would be about illness and monitoring needs, it would be based on medical and social needs. Similar to if a patient is going back to work, we wouldn't assume that they are well enough to withdraw support from them. If anything we encourage people to go back gradually. We see a lot of people who are in work.

Mental Health Service Manager NHS 027 62-65

5.3.4.h Education as a pathway to recovery

Probably half of our clients go on to some form of further or higher education. Community studies show that around 10% of young people are affected by mental health problems, although they may not seek treatment, so there will be many students affected in a college.

Psychiatrist NHS 022 59-61

There needs to be good practice spread throughout. There is something about early intervention projects, that is the time we see clients going through adolescent services and adult services but then there is education in the middle (not forgetting that that education is now for all ages). There is a need to look at key points in people's pathways.

Mental Health Service Manager NHS 014 117-120

The group targeted by Assertive Outreach are young people with a dual diagnosis, with complex problems, those who are difficult to engage with, that can't commit to services such as Restore. A lot of these people have started but not completed university courses and may want to go back. They had lots of potential and find that it is difficult that they can't reach that potential. It is difficult for them to accept that they cannot now complete their studies. However, there are other courses e.g. Open University where the social interaction and level of commitment is different.

Mental Health Service Manager NHS 023 79-85

Lessons could be learnt from the learning disability model about providing support and integration. The stigma of mental illness makes it different though.

Mental Health Service Manager NHS 023 90-91

It would be good to have an education worker to refer patients to. A specialised education worker role. At present clinicians have to trawl around for information on courses, that is where a community support worker is useful. Or even to have someone here that I could access.

It is good for people to come us, like the Learning Centre do, and remind us of what is out there.

Mental Health Service Manager NHS 027 119-122

We should note the political level and how it influences downward through institutions. The lifelong learning / widening participation agenda increases the pressure to take students on. The idea that everybody is fit for HE, if taken too far, is unhelpful. There are some student clients I have seen in my previous role where I thought how on earth were they taken on? They did not have the ability and it was eventually harmful to that person. It needs to be thought about. Higher Education is not a good thing full stop.

Psychotherapist NHS 017 179-184

5.3.5 Views on the quality of mental health services

We have had a locum psychiatrist since March and sometimes no one at all. There has been cross cover from the academic psychiatrist rather than the CMHT. The individual psychiatrist is great but there has been a lack of continuity.

General Practitioner NHS 002 183-185

I don't feel that I have been good at this [working with academic institutions] as the job has been appalling and I have been so busy. 60,000 in my patch is twice as big as it should be. The appointment of a fifth consultant will make a real difference.

Psychiatrist NHS 003 84-86

I had a student client with a recurrent mental health problem who did not have enough community support, and was using the counselling service as a substitute. There have been a couple more like that, students who have had CPN based support at home and don't get it here.

Counsellor OXB 006 170-172

I get the impression that university towns are not well resourced in health provision and that student patients need to be resourced.

Occupational Health Practitioner OXU 014 116-117

With the experience of the Littlemore [psychiatric hospital] assessment there was the frustration that the problem wasn't resolved through official channels and I am left with the feeling it is still an open file somewhere. Something else was needed The doctor said that if I had come some months earlier I could have accessed the support services attached to the Health Centre. It is a real shame that it was taken away....

Student OXB S02 166-173